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Medicine and Politics among the Grand River Iroquois

A Study of the Non-Conservatives

Sally M. Weaver

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Medicine and Politics among the Grand River Iroquois

A Study of the Non-Conservatives

Sally M. Weaver

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Résumé

Cette étude est consacrée à l'acculturation médicale des quelques 3,000 Iroquois non traditionalistes de la réserve des Six Nations, c'est-à-dire les Chrétiens. Elle a pour but de déterminer la nature et l'étendue de leur dépendance des techniques médicales occidentales tant au sein de la famille que de la communauté. Puisque les Iroquois se sont acculturés à une société blanche hétérogène, il semblerait normal que leurs croyances et leur comportement dans le domaine médical reflètent cette hétérogénéité.

On a établi que les Iroquois se fiaient à la médecine occidentale dès la fin du XIX^{e} siècle, que cette confiance devenait plus évidente entre 1900 et 1927 et qu'elle s'établissait fermement entre 1927 et 1950. La période s'étendant de 1950 à 1966 a vu naître bon nombre de mesures administratives extrêmement impopulaires. Les non traditionalistes ont réagi violemment à celles-ci, considérant que les nouvelles pratiques hospitalières et que le rôle fonctionnariste du praticien menaçaient leur recours à la médecine occidentale. En dépit de cela, au cours de cette période de crise, on fit appel aussi fréquemment aux soins médicaux que durant la période précédente où chacun se montrait satisfait de l'administration des services de santé.

Les non traditionalistes avaient une connaissance plutôt mince des herbes médicinales de la tradition iroquoise. Leur usage se limitait à quelques maux bénins ou à des cas extrêmes. Toutefois, ils conservaient fièrement leur confiance en l'efficacité des herbes, mais elle se fondait, pour une bonne part, sur leurs effets thérapeutiques reconnus, confirmés par leur introduction dans la pharmacopée moderne.

Pour déterminer les différences sociales au sein de la communauté non traditionaliste, on eut recours à une méthode de jugement. Les informateurs reconnaissent deux classes de citoyens, l'une supérieure et l'autre inférieure. Au sein de chacune, ils entretiennent les mêmes croyances au sujet des remèdes et de la pratique médicale. Les différences d'idéologie et de soins tant au niveau de la famille qu'à celui de la communauté semblent reliées à ce que la classe supérieure s'acculture à un modèle de blancs de classe moyenne alors que la classe inférieure s'acculture à un modèle de blancs de classe inférieure.

On a pu remarquer que la récente démarche pour changer les normes de santé de la communauté s'est faite à l'instigation de la classe supérieure seulement. Elle s'est développée à partir de deux concentrations de pouvoir déjà existantes: le conseil de la bande et l'élite, dont les idées s'opposaient principalement pour des raisons pécuniaires. Les changements finalement effectués à cause des pressions de l'administration fédérale démontrent que l'élite innovatrice avait accepté et le principe et l'urgence de procédés modernes. Dans ce sens, elle a contribué à accélérer l'intégration culturelle à l'ordre socioculturel dominant.

Summary

This is a study of medical acculturation among the 3,000 non-conservative (i.e., Christian) Iroquois on the Six Nations Reserve. Its purpose is to determine the nature and extent of non-conservative reliance on Western medical technology in both the family and the community. Since the Iroquois have been acculturating to a heterogeneous white society, it was expected that their medical beliefs and behaviour would reflect this heterogeneity.

It was found that non-conservative dependence on Western medicine was somewhat apparent in the late 1800's, more evident between 1900 and 1927, and firmly established between 1927 and 1950. The period from 1950 to 1966 was marked by many extremely unpopular administrative policies to which the non-conservatives have reacted intensely, considering the new hospital practices and the physician's role performance to be a threat to their access to Western medicine. In spite of this, however, medical services were utilized as extensively during this crisis period as during the previous period, which had been characterized by satisfaction with the medical administration.

The non-conservatives' knowledge of traditional Iroquoian herbal remedies was found to be meagre, and the use of such remedies was restricted to minor ailments or to cases of terminal illness. A generalized pride in herbal remedies was found among the non-conservatives, but it derived significantly from the validation of the efficacy of these cures by their incorporation into modern pharmacopoeia.

Using a judgmental method to determine status differentials within the non-conservative community, it was found that informants recognized two categories, termed higher status and lower status. Informants within each of these categories were found to have similar medical beliefs and practices. The differences in medical ideology and practice at both the family and community levels were attributed to the fact that the higher status are acculturating to a white middle-class model, whereas the lower status are acculturating to a white lower-class model.

Recent action to alter community health standards was seen to be instigated by the higher status category only, and to develop from two pre-existing power foci: the band Council and the elite (i.e., those who avoid direct political participation but contribute leadership in certain voluntary associations). The conflict that repeatedly occurred between the two groups was found to arise from the lack of public financial power of those promoting sanitation changes (i.e., the elite) and from the lack of immediate interest of those who had the authority to sanction change (i.e., the Council). The changes, ultimately effected by pressures from Federal Government personnel, demonstrated that the innovating elite had accepted both the ideas and the urgency of modern health improvements, and that they had, in this sense, been a factor in creating greater cultural integration with the dominant sociocultural system.

Biographical Note

Sally M. Weaver, Assistant Professor at the University of Waterloo, is a graduate of the University of Toronto. Her special interests include medical acculturation and political change among the Grand River Iroquois, the latter being her contemporary research. She has recently co-directed the preparation of the Canadian Indian Bibliography, an annotated compilation to be published in the summer of 1972, and is presently a member of the executive of the Canadian Sociology and Anthropology Association.

Preface

This monograph is a revised form of my Ph.D. dissertation written for the Department of Anthropology, University of Toronto in 1967. Changes have been made in two major areas. First, the three non-conservative status groups delineated in the thesis (higher, middle, and lower) have been reduced to two (higher and lower). The combination of the middle and lower status groups into the lower status category was made not because distinguishing features are absent but rather because, on the basis of health-illness behaviour, the difference was not significant. Secondly, the discussion of the illnesses that brought individuals in the two status categories to the hospital has been reduced to consideration only of those conditions that distinguish the two status groups in their hospital contacts.

Medical and sanitary events following 1966 have been briefly described in the addendum.

During my first three months of field-work on the Six Nations Reserve in the summer of 1963 I found abundant evidence that medical matters were in a critical state. At that time I was collecting material on the Six Nations women's response to a Public Health program for an M.A. research paper for the Department of Anthropology, University of Toronto (Weaver 1964). During my field-work I gathered data on the medical beliefs and practices of both the conservative and non-conservative members on the reserve.

The term "conservatives," as defined by Shimony (1961: 12,14) and as used in this study, refers to those approximately 1,500 Six Nations people who adhere to a religion that combines both aboriginal Iroquois and Christian (Quaker) beliefs, and who, generally speaking, oppose acculturation. They trace descent matrilineally, recognize clan and moiety affiliation, and support the hereditary chieftainship, not the elected Council. I shall use the terms "conservative" and "Longhouse" interchangeably. The "non-conservatives," on the other hand, are Christians. They trace descent bilaterally, recognize no clan and moiety affiliations, and divide their allegiance between the hereditary and the elected forms of local government. Unlike the conservatives, the approximately 3,000 non-conservatives do not maintain a closed cultural system. The term "non-conservative" is perhaps cumbersome, but I prefer it to the usual alternative of "progressive" because the latter term is used locally in reference to a political viewpoint, certainly not held by the majority of Christian Iroquois.

By the end of the summer of 1963 it had become obvious to me that the medical crisis derived from the non-conservatives' discontent with the current federal administrative policies and procedures. Although the conservatives were not altogether silent on the issues, they made no effort to oppose or alter the existing policies. Indeed, interaction and joint purpose among conservatives and non-conservatives were seen to be minimal, though clearly not characterized by derision. It was at this point that the concept of this study began to take shape.

Field-work during the summer of 1963 was supported by financial assistance from Dr. F.W. Voget, then of the University of Toronto, under contract with the National Museum of Canada. Research during 1964 and 1965 was largely subsidized by a contract obtained in 1964 from the National Museum of Canada. I gratefully acknowledge the financial support received from this institution. I obtained additional aid for the final few weeks of field-work from a Student Bursary offered by the Graduate School of the University of Toronto arranged through Dr. T.F.S. McFeat.

Over the three-year period of this study I have enjoyed the assistance and cooperation of many teachers, of the Six Nations people, and of administrators.

For his guidance and financial support during my first summer's field-work and for his willingness to discuss my work and exchange ideas and data, I give special thanks to Dr. F.W. Voget of the University of Southern Illinois.

To my original thesis committee, composed of Dr. P.V. Ottenberg (chairman) and Drs. R.C. Dailey, T.F.S. McFeat, J.W. VanStone, and D.E. Wilmott, and to my second thesis committee, including Dr. R.W. Dunning as chairman and Drs. W.P. Carstens, J.N. Emerson, J.J. Loubser, T.F.S. McFeat, and S. Nagata, I am indebted for their encouragement and valuable criticism, as I am to Dr. J. Anderson, who took time to read parts of the manuscript.

To the many Six Nations people who willingly and patiently assisted me in my work, and without whose cooperation this study would have been impossible, I extend my sincere appreciation. In particular I wish to thank the Six Nations Council for their permission to reside on the reserve during the period of data collection, and Mr. H. Fishcarrier, Secretary to the Council, and Mr. A. Anderson, Jr., Welfare Officer, for their cooperation throughout the period of field-work.

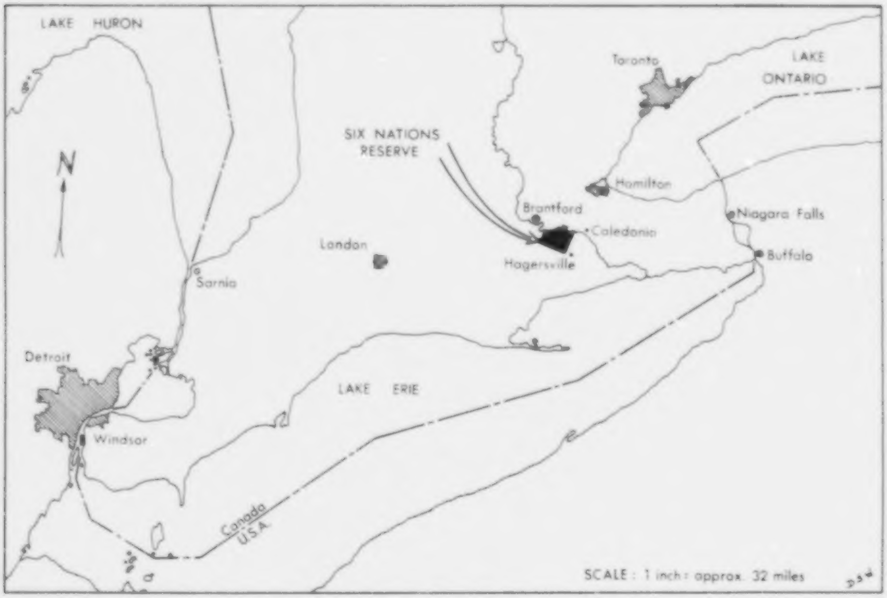
I am especially grateful for the friendship and continuing kindnesses shown me by David and Blanche Moses and their two children, Daniel and Debora. To Mr. and Mrs. Elliott Moses, the parents of David, and Mr. and Mrs. George Jamieson, the parents of Blanche, I extend thanks for their guidance, generous hospitality, and friendship.

To all the staff of the Six Nations Indian Agency appreciation is most certainly extended: to Mr. D. Cassie, Agency Superintendent, and Mr. J. McCaw, Assistant Superintendent for their interest in my work and their continuous cooperation; to Mr. W. Horne and Mrs. G. Priestley for their kind assistance in locating and interpreting many of the records utilized; and to Mr. J.C. Hill for his cooperation in supplying information on the reserve school system. My very special thanks go to Messrs. J.W. Hill and N. Martin of the Estates Division of the

Agency whose experience with the old records and guidance in clarifying problems proved invaluable to me, as did their willingness to discuss my ideas.

I am most appreciative of the generous assistance provided by the staff of the Lady Willingdon Hospital, in particular Medical Superintendent Dr. G. Nicholas and public health nurses Miss H. Aird and Miss A. Whittaker. Their knowledge of the community and their willingness to have me observe their clinic and home-visit procedures were of great value to me.

To my mother, Mrs. Muriel Willson, I extend my deep gratitude for her careful editing of the rough draft and for her sustained interest in my career and this study. To my husband, David, who patiently put up with our separations while I was in the field and who painstakingly edited the final draft go my continuing respect and gratitude. Without his encouragement the completion of this study would have been impossible.


LAKE HURON
N
SIX NATIONS RESERVE
Toronto
LAKE ONTARIO
Hamilton
Brantford
Caledonia
Niagara Falls
Buffalo
London
Hagersville
Sarnia
Detroit
Windsor
LAKE ERIE
Canada
U.S.A.
SCALE : 1 inch = approx. 32 miles

Map 1. Southern Ontario.

Introduction

The physical reserve

The Six Nations Reserve is a ten-by-eight mile block of land containing some 44,900 acres of fertile farming land on the south bank of the Grand River in the townships of Tuscarora and Onondaga in Brant County, and in Oneida township in Haldimand County, Ontario (*see* Map 1). On the north side of the river only a small two-square-mile section remains to the Iroquois. To the southeast of the reserve and directly adjacent to it is the Mississauga Reserve and, together, the two comprise the Grand River Reserve. The Mississaugas who were formerly located on the Credit River were granted this land by the Six Nations. In 1842 they settled in this small 4,800-acre area. These Mississauga Chippewa are not included in this study.

According to the last published Indian census (1959) the total number in the Six Nations band was 7,304 (Canada 1961: 16). Of these, 4,350 lived on the reserve, and 2,923 had established residence elsewhere. In 1965 the Six Nations Agency estimated that there were 8,200 members in the band, of which 4,500 resided on the reserve and 3,700 lived off the reserve. According to the 1959 census, 45.85 per cent of the band population was under the age of 21, and 52.95 per cent was over 21. The percentage of those whose age was not stated was 1.17. Of those under 21, 15.51 per cent were under 6 years, 21.54 per cent were between 6 and 15 years, and 8.80 per cent were between 16 and 20 years. The percentage of males in the population was 50.47, and that of females was 49.52.

The settlement pattern is still a rural one with houses (a total of 1,052) and farms located along the roads (Agency Housing Survey 1967). The densest settlement is along the east-west roads where the rectangular lots abut. Houses vary from old ones to modern split-level structures; most houses, except the newer ones, are of wood construction. The observer distinguishes between Indian and white countryside by means of the old log house, of which there are some 119 at present. This distinctiveness must not be striking, however, to the tourists who stop at Indian homes to seek directions to the reserve. The concession roads that grid the reserve are of gravel with the exception of one recently paved highway running east and west. Hydro was first extended to the reserve in 1927 when the hospital was built, and by 1950 it was potentially available to the entire reserve. Today, 70.8 per cent, or 745 of the 1,052 houses, are equipped for this utility. Telephone lines have been erected on the reserve in similar piecemeal fashion since about 1910, and today 59.6 per cent, or 628, of the homes have telephones. No centralized water or sewage system exists: each home has its own facilities. According to the 1965 Agency Housing Survey, "fully nine-tenths of the houses on the Reserve use an outside privy. Construction of this privy ranges from a few boards stuck together to good quarter-moon construction. It was noted that sixteen of the homes have no provision for sanitation. There is a good possibility that many of the other homes who have a privy do not make full use of this little building." The 1967 survey reported 7.2 per cent of the houses with indoor toilets and 10.4 per cent with running water. Water for drinking and general household use usually comes from a family well, but in cases where wells have not been dug, the family has to take water from a neighbour's well or purchase it in local towns.

Primary education is provided for the children in the twelve public schools located throughout the reserve (*see* Map 2). Of the total teaching staff of 50, 38 or 76 per cent, are Six Nations, including all the school principals and the superintendent. The high schools in the surrounding towns of Brantford, Hagersville, Caledonia, and the more distant Cayuga, with the exception of the last, all about one-half to three-quarters of an hour's drive from the centre of the reserve, provide secondary education for the children. Buses operated from the reserve by Six Nations men provide the transportation to these outside schools. It is in these towns that most of the shopping for food, clothing, and appliances is done, the town chosen usually being the closest to the family's location on the reserve. The reserve contains about twelve general stores, many with gas pumps in front, located for the most part on corners, but these tend to be used for small quantity buying.

There are in all fifteen churches: five Anglican, three United, three Baptist, two Pentecostal, one Mormon, and one Seventh Day Adventist. In addition, there are five mission buildings and four longhouses. One sect (Jehovah's Witnesses) has a small following but no building. With the exception of the two Pentecostal churches and the one Baptist, all the congregations are organized under the leadership of non-Indians. The buildings, which are scattered throughout the area, vary in style from century-old designs to contemporary ones.

The only exception to the dispersed settlement pattern is the village of Ohsweken, which has long been the seat of local government (*see* Map 3). Here, in what is sometimes referred to as the "capital" of the reserve, are located the Council House, the fair grounds with community hall, the hospital, the Royal Canadian Mounted Police headquarters, the funeral parlour, the post office, a senior public school, two junior public schools, three churches, two restaurants, four gas stations, and two general stores. The stores, gas stations, and restaurants are all owned and operated by Six Nations families.

Individual land holdings on the reserve are obtainable only by persons of Indian status enrolled on the Six Nations band list, and this status is defined patrilineally by the Federal Government in accordance with the Indian Act (1951). Although land cannot be permanently transferred by Indians to non-band members, a good portion of the arable land, about 5,130 acres,[1] is rented today to local white farmers. Only 6,742 acres are used by Indians for agriculture. The reserve is now a non-farming community; income is gained from external sources of employment, mostly in surrounding towns.

On week-days, visible activity on the reserve is at its greatest during the early morning and evening when the commuters leave home for work in local towns and return, and when the children either walk to and from school or are collected and returned by the school buses. In the village, activity is somewhat heightened at noon hour by school children walking to the stores to buy candy and "pop" and by the occasional teacher having lunch in a restaurant. The village again becomes alive at supper time when the commuters stop off to buy items in the general stores before driving home.

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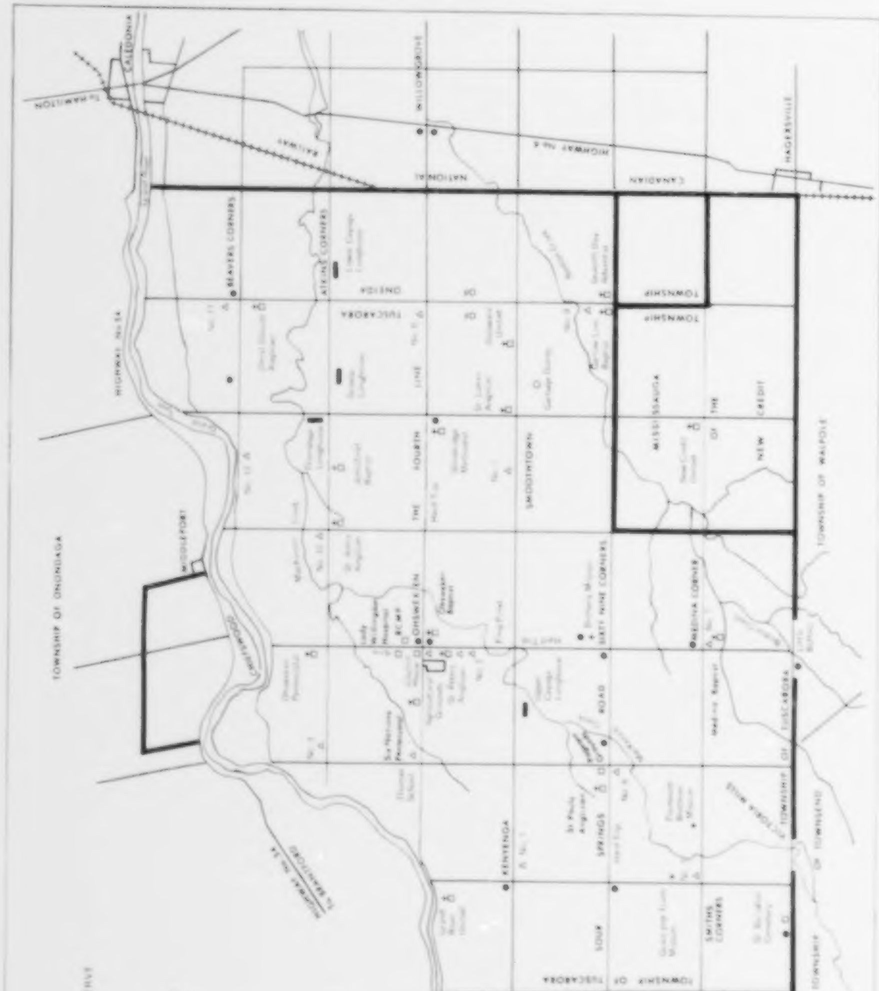
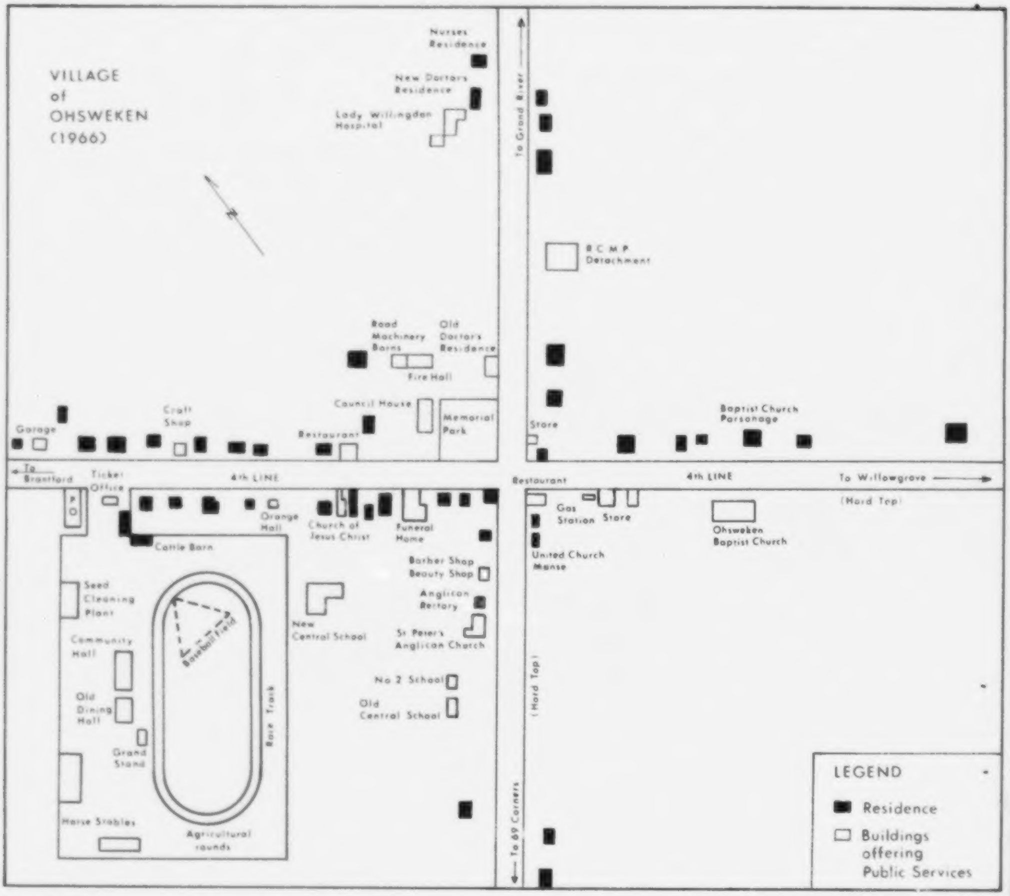
[1] Information on land usage was obtained from an Agency survey dated 1963.


GRAND RIVER
SIX NATIONS RESERVE
STORE
CHURCH
MISSION
LONGHOUSE
SCHOOL
TO HAMILTON
CALEDONIA
HIGHWAY No 54
TOWNSHIP OF ONONDAGA
MIDDLEPORT
BEAVERS CORNERS
ATKINS CORNERS
WILLOWGROVE
RAILWAY
HIGHWAY No 6
NATIONAL
CANADIAN
HAGERSVILLE
ONEIDA
TUSCARORA
THE FOURTH LINE
SMOOTHTOWN
OHSWEKEN
R.C.M.P.
SIXTY NINE CORNERS
MEDINA CORNER
MISSISSAUGA OF THE NEW CREDIT
TOWNSHIP
TOWNSHIP OF WALPOLE
TOWNSHIP OF TUSCARORA
KENYENGA
SOUR SPRINGS ROAD
SMITHS CORNERS
TOWNSHIP OF TUSCARORA
TOWNSHIP OF BRANTFORD
TOWNSHIP OF TOWNSEND
HIGHWAY No 54 TO BRANTFORD
TO BRANTFORD

Map 2 Six Nations Reserve


VILLAGE
of
OHSWEKEN
(1966)
N
Nurses Residence
New Doctors Residence
Lady Willingdon Hospital
To Grand River
RCMP Detachment
Road Machinery Barns
Old Doctor's Residence
Fire Hall
Council House
Memorial Park
Garage
Craft Shop
Restaurant
Store
Baptist Church Parsonage
To Brantford
Ticket Office
4th LINE
Restaurant
4th LINE
To Willowgrove
(Hard Top)
P O
Orange Hall
Church of Jesus Christ
Funeral Home
Gas Station
Store
Ohsweken Baptist Church
United Church Manse
Cattle Barn
Barber Shop Beauty Shop
Seed Cleaning Plant
Anglican Rectory
New Central School
St Peter's Anglican Church
Community Hall
Baseball Field
Old Dining Hall
No 2 School
Old Central School
Race Track
(Hard Top)
Grand Stand
Horse Stables
Agricultural rounds
To 69 Corners
LEGEND
■ Residence
☐ Buildings offering Public Services

Map 3. The village of Ohsweken, 1966.

Sports activities, such as baseball, provide foci for gatherings, often in the village ball park. Construction of an arena or a rink was planned as the community's centennial project, but at the time of writing neither had been built.

Throughout the year, general activities of the many voluntary associations take place primarily in the homes, in the churches, or in the community dining hall on the fair grounds. Council days, the first Thursday of each month, see more activity at the Council, but those who come to listen in are few, ranging from a couple of persons to some fifteen or twenty at regular sessions. An issue of particular interest, however, such as the questioned right of the city of Brantford to sell the city square, which is thought by many to belong to the Six Nations, will draw a much larger audience.

Regular holidays such as Easter, Victoria Day, Labour Day, Thanksgiving, and Christmas bring many non-residents back to visit their families. In mid-August tourists are drawn to the reserve to see the pageant. Each year the drama is performed with a distinctively Six Nations theme, such as the life of Joseph Brant or of Pauline Johnson, the poet. The occasion not only allows expression of ethnic pride, but also provides the opportunity to sell locally produced crafts.

But two special events, the "Bread and Cheese Day" and the Fall Fair, bring observable community activity to a peak. The former event, held on the 24th of May and organized by the Council, is held in the community hall. Many hundreds turn out and line up for their gift of bread and cheese, a token originally given the Six Nations by the Crown in appreciation of their longstanding loyalty. Although each year the quantities of both bread and cheese are increased, "they always run out." In the afternoon there are sports competitions for children, and the sound of firecrackers punctuates the entire day. The Fall Fair, held in late September, brings equal, if not greater, crowds including many whites. Horseraces, Indian dances, the conferring of Indian names, and the many competitions for farm produce, baking, sewing, painting, crafts, and children's school projects may make the day personally rewarding as well as socially enjoyable. The Ploughing Match, held on the reserve every other year in the late fall, is the last community event of the year, but it does not draw the same crowds as the other two do. Among the competitors are many white farmers from the county, and the winners are presented with their prizes at the banquet held that evening in the community hall. Catering for banquets and wedding receptions is usually undertaken by one of the many women's groups on the reserve, either a church guild or one of the two branches of the Women's Institute. It is evident that the community is essentially a rural one, except that its economy is not based on farming.

SIX NATION
COUNCIL
1863

Plate I. Six Nations Council House, Ohsweken.

The problem

This is a study of the history of medical acculturation from 1850, when the first permanent resident physicians were hired to serve the Six Nations, to 1966. Its purpose is to document and analyse the process of increasing dependence upon Western medicine by the non-conservatives and the role this reliance has played in the reserve community and in Six Nations relations with the dominant Canadian society.

The non-conservatives, who are the more acculturated Six Nations, are, for the most part, Christians; they represent one of the two sociocultural groups into which the Iroquois have aligned themselves on the basis of religious affiliation. The other group is the Longhouse people, or conservatives, who adhere to the teachings of the Seneca prophet Handsome Lake and, in general, oppose the loss of their way of life (*see* Appendix A). It is with the non-conservatives that this study is concerned.

Medical customs *per se* on this reserve are of anthropological interest because of the significant role these customs play in the continuing process of acculturation. It has been demonstrated that, to the conservative Iroquois, concern for one's personal well-being operates in such a way as to perpetuate their more traditional way of life, which is most clearly manifested in Longhouse activities (Rioux 1951; Shimony 1961, 1961*a*). Because of the long-standing ethnological preoccupation with these more conservative Iroquois, a complementary understanding of the medical beliefs and practices of the non-conservatives, indeed the non-conservative pattern itself, is unavailable. It is the purpose of this study to begin to fill this void.

Since the acculturative process involves systems (Broom et al. 1954: 974), it is self-evident that medical affairs will affect and be affected by other aspects of the joint contact cultures, albeit to varying degrees. In this respect it will become clear that politics and medical matters are inseparable at the community level of organization. It will further be established that the contemporary dilemma of the non-conservatives is ultimately due to the impossibility of selectivity in their acceptance of Western medical practices. Their inability to choose the more satisfying aspects of the past and present Western medical complex and to create a gratifying blend stems not only from the policies of the federal administration but also from the very nature of the complex itself.

It is of paramount importance to understand that the Six Nations have long been exposed to the Western medical complex. Since the mid-nineteenth century physicians have been permanently resident on the reserve, and since 1927 a hospital has been in operation in Ohsweken. As have other aspects of the donor culture, the medical institution has undergone major changes both in technology and in the roles of the professional personnel. Because of this changing complex, the Six Nations have been required to continually adapt their behaviour and to readjust their expectations of role performances of medical personnel.

It is evident that greater dependence on Western medical technology will result in greater apprehension over any real or perceived threat to access to this medical complex. Indeed, it was the heated reaction of the non-conservatives to such a threat that initially drew my attention to this problem and prompted me to study it more carefully.

With increasing reliance on Western medicine one would also expect to find signs of decreasing reliance on the traditional Iroquois medical beliefs and practices still adhered to by the conservatives. This is not to imply that adherence to one form of medical technology precludes reliance on another: the conservatives themselves demonstrate this dual dependency pattern, referred to as a "double security system" by Rioux (1951: 158). The general dissociation between conservatives and non-conservatives, and certain religious factors discussed in a later chapter, would indicate such loss of traditional medical lore.

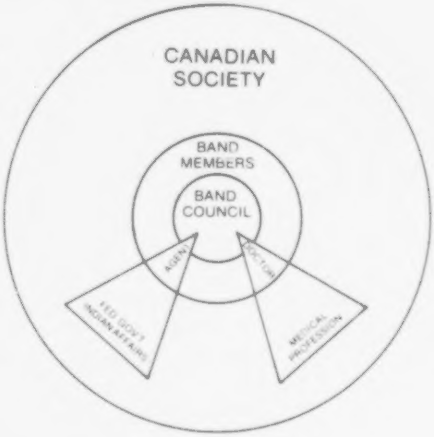
The contact situation between the non-conservatives and the Western medical complex will be approached on two levels of analysis: (1) doctor-hospital and community, and (2) doctor and patient. The models presented graphically below must be viewed as diachronic ones, with their components changing throughout the years from 1850 to 1966.

In the community model (*see* Diagram A), the local band Council is directly contacted by two institutional complexes: the federal Indian administration represented by the Indian Agent, and the Western medical profession represented by the reserve physicians.

The triadic relationship among the officials has, at times, been fraught with difficulties: conflicting ideas about the nature and extent of medical treatment to be given locally, vain struggles of the Council to gain authority over medical matters, and clashing personalities. Unlike the conflicts of the past, however, those of the mid-1950's were instigated by the physicians' becoming hospital based, by the pressure groups' organizing improvements in medical treatment and sanitation on the reserve, and by the Federal Government's curtailing of the operations of the local hospital. This threat to the Six Nations access to modern medicine was real, but only to the extent that reserve-based medical facilities were being partly withdrawn, thereby compelling the Six Nations to go to local towns for the more complicated forms of diagnosis and treatment.

Diagram A

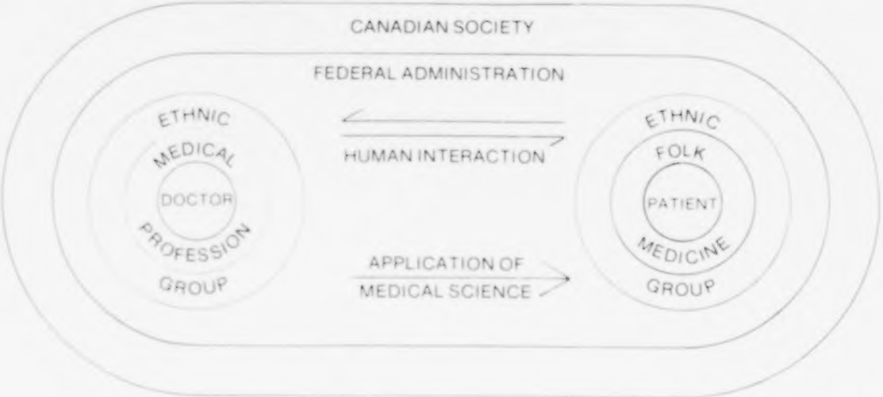
Community Model



The second level of analysis, the doctor-patient relationship (*see* Diagram B modified from Bloom 1963: 63), entails an examination of both medical and non-medical factors, such as the role performance and role qualifications of the physicians; changes in the Western medical complex, folk medical beliefs, and practices held by the non-conservatives; and ethnic group membership. Of particular concern is the changing

Diagram B

Doctor-Patient Model



role of the patient: no longer accommodated in his home by the country doctor, he must accommodate the physician in the hospital. In the dyadic relationship of doctor and patient, the former role cannot be expected to change without complementary alterations in the latter.

Although the doctor-community relationship is historically well documented, data on the doctor-patient relationship are not so frequently available in the old records. The information is sufficient, however, to allow a general description of the relationship as it existed in the late 1800's, an era beyond the memories of the oldest informants.

It is also necessary to examine the extent to which ideas of hygiene and good health are accepted and followed by the individual family. As Firth claims:

> . . . more and more, as the gross medical problems are being met, the tendency is for responsibility for the maintenance of personal health to rest on the individual himself. Exercise, rest, diet, alcohol intake, reporting of illness, avoidance of contagion require in the last resort, for adults at least, a personal care and a personal decision. The problem here is how to condition the individual to take medical care of himself. In the long run a vast amount of health work must take place in the home. It is in the home, as health educators well realize, that the implementation of most new ideas is ultimately required. Here is the test of new concepts. And here is apt to be the most refractory field of operation (1959: 162).

Here, beyond the immediate effective range of the physician's prescriptions and regimens, the heterogeneity of medical beliefs among the non-conservatives is most evident.

In an examination of the diversity of medical belief and behaviour, it is imperative to note the characteristics of the model to which a group is acculturating (Mason 1955; Kupferer 1962, 1963; G. Spindler and W. Goldschmidt 1952; L. Spindler 1962). The non-conservatives are acculturating to a sociocultural system that is socially stratified and consequently contains disparate ideas and behaviour relating to health and hygiene (Koos 1954). One would, then, expect the non-conservatives to reflect this diversity, both in individual and in community action regarding health and illness.

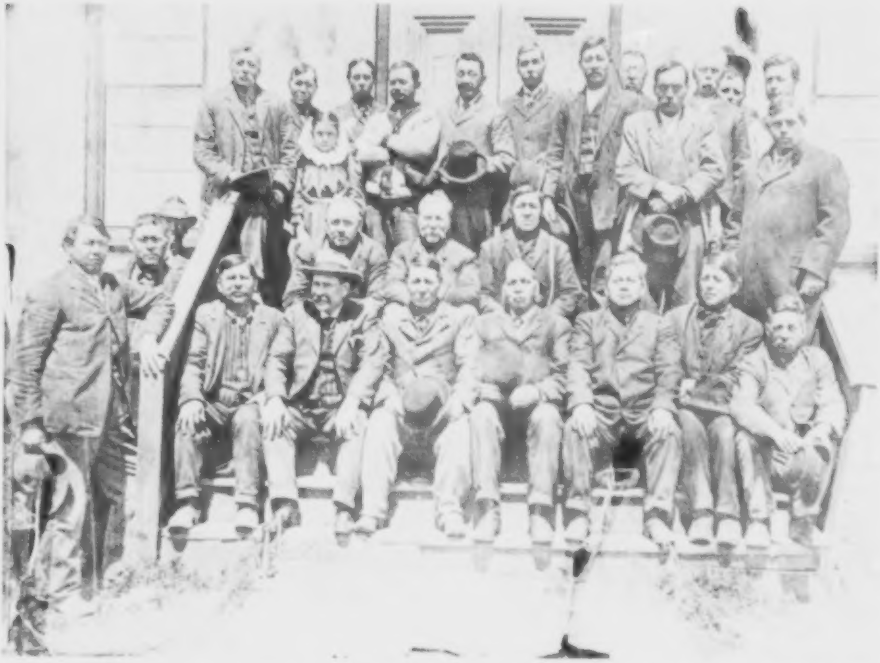


Plate II. Six Nations Hereditary Chiefs in front of Council House, 1910. Standing back row, L to R: Abram Lewis, David Jamieson, J.W.M. Elliott, Alex McNaughton, Wm. Smith (Interpreter), A. G. Smith, Harry Martin, Richard Hill, Robert Isaac, W. C. Hill, Peter M. Jamieson, Sam Lickers (back), Thomas J. Thomas (front). Standing L of rail, from front to rear: M. Smoke, George Gibson, S. Bumberry. Seated second row from back, L to R: A. H. Lottridge, George P. Hill, David John Sr. Seated front row L to R: Peter Clause, Jacob S. Johnson (Deputy Speaker), J. C. Martin (Speaker), Josiah Hill (Secretary), John Gibson, Johnson Sandy, Joseph Powless. (Courtesy Six Nations Agency Archives).

Chapter I

Historical Background of Iroquois Culture and Acculturation

The period from contact to 1784

At contact in the early 1600's an estimated 10,000 Iroquois occupied the area of New York State. The mixed subsistence bases of the tribes (Mohawk, Oneida, Onondaga, Cayuga, Seneca, and the Tuscarora, who joined the Confederacy in the early 1700's) included horticulture, gathering, and hunting. The women were the primary cultivators. Warfare, rather than hunting, was the most prestigious pursuit of the Iroquois male. The land surrounding the villages, which was used for growing corn, beans, and squash, was allocated by clans composed of matrilineages. The matrilocal extended family was the basic form; marriages, arranged by the mothers of the bride and groom, were monogamous. Each extended family occupied a bark longhouse, and a group of several such longhouses formed a village, which was often surrounded by a palisade. Hunting territory was owned by the tribe, not the clan.

Political organization was patterned on a kinship basis. The offices of sachem, or peace Chief, were hereditary in the lineage, the choice of a candidate being strongly influenced by the lineage matron. The Chiefs in each of the six tribes convened to decide matters relating to their own tribes. Once a year, and whenever emergencies arose, all the tribal sachems met as a collective body to debate issues, such as peace and war, pertaining to the league as a whole.

These annual councils were held at Onondaga, the "capital" village of the League, in the territory of the tribe that had the greatest representation on the Grand Council of fifty sachems. The Grand Council was conducted in accord with kinship forms; the tribes were divided into two opposing moieties, and when a consensus was reached independently in each moiety it was then put forth by speakers, the eventual ideal being unanimity on any decision. The terms of address used in council were kin terms.

The first Europeans to have a significant impact on the Iroquois were the Dutch, who, from their base at Fort Orange on the Albany River, began a trade in beaver pelts in 1615. Trade flourished until the 1640's when the beaver became scarce. The Iroquois, by then reliant on trade goods and hampered by decreasing quantities of furs to trade, began forcibly to compel tribes living to the north and west to become their sources for pelts. These "Beaver Wars" terminated in the 1670's, a few years after the British traders replaced the Dutch. In spite of this vigorous effort, the supply of beaver did not increase.

The economic problems of this period were soon joined by political ones: alliances developed between the Huron and French on the one hand and the British and Iroquois on the other. This latter alliance, rooted in the "Beaver Wars" and the struggle for Canada, continues to be a significant factor in the Iroquois-white relations of some members of the Six Nations in Canada.

The breakdown of Iroquois political sovereignty culminated at the time of the American Revolution. Unable to reach a consensus about its role in this struggle, the League was torn apart: some tribes actively supported the British, others remained neutral, and others passively supported the Americans. During the revolution, Joseph Brant, a Mohawk, actively fought for the British; after Britain's loss of the colonies in 1783 he led a group of Six Nations to Canada to settle on a grant of land given them by the Crown. Fourteen years after this resettlement in Canada, a revitalization movement occurred among the Seneca of New York State; the message was not long in reaching the Ontario Iroquois (*see* Appendix A).

History of the Grand River Iroquois, 1784-1900

Land acquisition and loss

As indemnity for the loss of their lands after the American Revolution the Mohawks and their fellow tribesmen who wished to reside in Canada received a large tract of land that the Governor of Quebec, Sir Frederick Haldimand, had purchased in 1784 from the Mississauga Indians. The original deed, a grant in fee simple of approximately 570,000 acres, defined their lands as being to a depth of 6 miles on each side of the Grand River from its mouth to its source (Noon 1949: 86). At this time the headwaters of the river were scarcely known, and in subsequent years Iroquois possession of these lands, possibly never intended, was never established (Johnston 1964: xxxix-xl):

In the fall of 1784 and the winter of 1785, about 1,600 Iroquois emigrated from New York State through the Niagara Peninsula to the Grand River and settled in small tribal settlements along its course, the Cayugas near its mouth, and the Mohawks, the most distant, near the present site of Brantford. All six tribes were represented, but the Mohawks were the most numerous and the most politically influential (Johnston 1964: xl). One accounting of tribal numbers in 1785 listed the following: 450 Mohawk, 380 Cayuga, 200 Onondaga, 125 Tuscarora, and 75 Seneca and a few Oneida (Johnston 1964: xl). In addition, small numbers of Delaware, Nanticoke, Tutelo, Creek, and Cherokee accompanied the Six Nations; however, with the exception of the Delaware, their influence on reserve life has been negligible.

Governmental assistance in this settling came from Governor Haldimand, who had made provision for a mill, a church, a school, and a teacher (Johnston 1964: xl). The three buildings were eventually erected in the Mohawk settlement near Brantford, but their subsequent use and benefit to the Indians were slow in materializing.

The dominant figure throughout this period of relocation and settlement of the Six Nations in the valley was the able politician and leader, Joseph Brant, a relentless promoter of Iroquois national sovereignty. The final decision to locate in the valley was his, as was the later alienation of large blocks of the original grant to white settlers, most of whom were his friends (Johnston 1964: xxxvi, xliii).

It was Brant's persistent belief that the old economic patterns of the Iroquois could not be reinstated to their benefit in the valley. Not so much the belief itself, but rather the determined manner in which he put it into practice led to conflict both within the newly reconstituted Confederacy and with the governor of the newly created province (Johnston 1964: xlv-xlvi). From that time to the present, alienation of lands or even the perceived threat of it has been a critical issue.

The aim of Brant's land sales was to settle white farmers in close proximity to the Indians so that by example they could transmit to the Iroquois the skills and attitudes necessary for agriculture. The monies received from these land sales, Brant contended, were to be used during this difficult transitional period for food and other materials until the men could farm successfully enough to provide staples for the table and additional necessities of life.

In an attempt to clarify the issue of land alienation, John Graves Simcoe, Brant's adversary, formulated the Simcoe Deed of 1793, which prohibited land transfer to non-Indians. Brant and the Confederacy refused to recognize this deed as binding and continued to claim trusteeship for the Council of the Six Nations. Despite the objection of at least two sachems and of Governor Simcoe, by 1798 approximately 350,000 acres, or two-thirds of the original grant, had been transferred to white farmers by Brant himself (Johnston 1964: lv).

By the time the legitimacy of these deeds was finally settled in the late 1830's additional lands had been lost. These depletions heightened the fears of both the Confederacy and the Colonial government that the remaining lands would be insufficient for the needs of the Iroquois. Consequently, the 1830's and 1840's witnessed governmental pressure to secure the Indians' land. This movement, instigated by Sir Francis Bond Head (Johnston 1964: xciii), culminated in the Confederacy's surrender of the remaining Iroquois lands to the Crown on January 18, 1841. The legal formation of Iroquois lands as a reserve was realized the following year. Formerly an estate in fee simple, the reserve now constituted an "estate in leasehold from the British Crown" (Noon 1949: 87). Alienation of lands is now only possible through a referendum of the band members of the Six Nations.

By the mid-1800's, land sales had largely terminated, and most of the Iroquois living on the north side of the Grand River had moved to the south bank to escape the pressure of the white settlers who were encroaching on their lands. Resumption of nuclear tribal settlements had been impossible because of extensive intermarriage, so the Iroquois resettling on the southern bank established a rural settlement pattern in accordance with their farming economy.

Farming

During the early years of settlement the problem of acquiring a farming technology, which had brought about the whole land alienation conflict, was a difficult one. Parental instruction was not yet possible; formal instruction was given only to a very limited extent in a school in the Mohawk village. Thus, despite the fertility of the land and whatever degree of motivation the Iroquois may have had, the development of farming practices was slow.

By 1843 the population had increased to 2,223, and because of periodic crop failures and the apparent inability to stockpile grain, governmental assistance was needed, sometimes desperately (Johnston 1964: xcii). An 1842 census of the Six Nations gives a clear picture of the nature of farming in mid-century (Johnston 1964: 308).

> The land is not subdivided into regular plots. Each Indian selects his own locality, and takes as much land as he can cultivate, or wishes to reserve to himself, without the interference of the Chiefs. They are generally secure from the intrusion of other indians, and they can transmit their land to their heirs, or convey their interest in it to any other Indian. If any disputes arise, they are submitted to the Chiefs in Council, who decide upon the matter.
>
> They are much improved in their habits of industry and their mode of Agriculture, and they raise a greater variety of grain and vegetables than formerly; but it has been observed that their crops have been less abundant, and their horses and stock less numerous, than at former periods. This may be accounted for by a large portion of their cultivated land having fallen into the possession of white Settlers, and by the erection of certain dams on the Grand River, which have flooded much of their Marsh land, and obliged them to abandon it.
>
> The large farmers pursue exactly the same Mode of Agriculture as the Whites, except that they sow less seed, and are not so careful in preparing it. Hence their crops are frequently severely injured by smut — They sow wheat and oats, and grass down with timothy. They also grow peas in large quantities, with which, and Indian Corn, they fatten their Hogs — The small farmers grow little else than Indian Corn and Potatoes, in the cultivation of which they only use the Hoe — On the large farms, the field labour is performed by the men, with the exception of the cultivation of Indian Corn, which, on large or small farms, is always performed by the Women. The young men of the Upper Tribes, who are Christians, and further Advanced in Civilization, engage more in farm labor, and are more industrious than the young Men of the Lower Tribes, who are mostly heathens (Johnston 1964: 308).

Of those who did not farm, the census reports:

> In those cases in which the family has no improved land, the males generally work out in the Winter, chopping and carrying wood for fuel &c &c. In the spring and summer, and the early part of the Autumn, they engage as laborers, for which they receive high wages. The females remain with their relations, and are supported by the earnings of the Men — Many of the Indians Work on the farms of the White Settlers during harvest time, being excellent Cradlers of various Kinds of grain (Johnston 1964: 306).

It was not, apparently, until the end of the nineteenth century that farming apexed as a subsistence pattern and provided a focus for voluntary farming organizations, such as the Farmers' Institute and the Agricultural Society.

Education

The beginnings of formal education for the Iroquois in the Grand River Valley date back to missionary activity in the 1820's. Within ten years of the introduction in 1827 of the first resident clergyman, sponsored by the New England Company, four schools were built: two, east of Brant's Ford, served the Mohawk, Cayuga, and Oneida; one, down river, was for the Onondaga; and another, farther down, was for the Delaware (Johnston 1964: lxxxvi). Attendance at these schools was at first encouraging to the enthusiastic clergy, but it was not long until enrolment diminished (Johnston 1964: 301), partly because few children understood English and partly because some Chiefs questioned the usefulness of the three R's to children who would probably not use this training in their daily lives (Johnston 1964: lxxxii). Furthermore, the scarcity of reading material made it difficult for the Indian child or adult to maintain or increase his facility in reading.

Opportunities for formal education expanded slowly throughout the second quarter of the nineteenth century. Missionaries did some teaching in their church buildings on the reserve, but seldom on a full-time basis. The Mohawk Institute, a residential school built in Brantford in the 1820's, offered greater opportunity than the mission schools, and children of parents who were concerned about higher education were sent there to learn not only the three R's, but farming and domestic skills as well.

By 1889 there were twelve schools on the reserve to serve the population of some 3,384 Six Nations: nine established by the New England Company, two by the Methodists, and one by the Chiefs "independent of clerical supervision" (Canada 1889: 157). Education remained largely on a mission basis until after the turn of the century. When the band Council and the Indian Department assumed control early in the twentieth century, the number of schools did not increase, but the organization became secular and demanded higher teaching standards.

Religion

Farming was a common area of interest for most Six Nations during the 1800's, and thus it provided some force for unified action; however, religious beliefs and practices produced the very opposite reaction. The division into Christian and non-Christian, which developed before the 1784 resettlement period, carried over into their new locale, where it was eventually to intensify and spread to all aspects of reserve life (Noon 1949: 31). Today it is the major criterion for identification as conservative or non-conservative.

Although the religious affiliations of individual immigrants are not known, there seems little doubt that the non-Christians constituted the majority. Evidence for this stems from missionary reports in the second and third decades of the nineteenth century. In 1826 the Reverend John West, an Anglican, described the Mohawk, Oneida, and Tuscarora as "Professed Christians," and the Cayuga, Onondaga, and Seneca as "Heathens" (Johnston 1964: 253). Ten years later Reverend Nelles, Episcopal pastor to the Tuscarora settlement, is said to have claimed that of the 2,300 Iroquois on the Grand "the greater portion of them were still Pagan, preserving their several rites, observing their quarterly festivals, and sacrificing annually a white dog" (Johnston 1964: 262).

The revitalized form of aboriginal religion, which was not long in reaching the Six Nations on the Grand, probably led to a revival of ritual that had shown evidence of waning. In addition, it may have intensified this religious division, causing relations between the two groups to become less accommodative. One missionary, for example, refers to the Longhouse followers as "showing strong prejudice against our converted Mohawks" (Johnston 1964: 262). In this case, political reasons and the influence of missionaries themselves may well have contributed to this reputed prejudice just as much as a difference of religious belief.

As for the smaller Christian group, they were at first without missionary guidance. Despite the Indians' expressed desire, prior to the migration, to have religious instruction in their new setting (Johnston 1964: lxxix), and the wish of the Society for the Propagation of the Gospel to comply with this request, a resident missionary was not sent to the Grand until 1827 (Johnston 1964: lxxxv).

The apparent tenacity of the Longhouse religion and the scant evidence that their work was progressing at first discouraged the missionaries. In fact, Baptist intentions to establish a missionary in the area were temporarily dampened by the disheartening situation. From the 1830's to 1900, however, clergymen from the various Protestant faiths came to the valley and gradually converted most of the Six Nations to Christianity. By 1889, according to the information in the Indian Superintendent's annual report (Canada 1890: 158), 63.98 per cent of the population of 3,384 was Christian, 20.21 per cent Longhouse, and 15.78 per cent of unknown affiliation. As they do today, the Anglican and Baptist denominations claimed the highest percentages of Christian adherents, 30.49 per cent and 18.05 per cent respectively.

Politics

Although the nature of the reconstruction process of the League is not described in the literature, it is known that the Council fires[1] were rekindled at the Onondaga village shortly after the Iroquois settled in the Grand River Valley (Johnston 1964: 107). This reinstatement held deep significance for the Six Nations, because it thereby established firm continuity with traditional political patterns and a "familiar point of reference around which life in a new land could be organized" (Noon 1949: 18).

The League, according to custom, had been a political body whose domain was intertribal and international. The soon-fading tribal territorial distinctions in the new locale, never deeply entrenched because of intermarriage, deprived the Confederacy of this responsibility (Noon 1949: 42). The Confederacy's claim of sovereign status as a nation with power over international issues has provoked a long and difficult struggle without success to date. Thus, lacking one old responsibility and denied the other, the League was, by the very nature of reserve life, gradually transformed into a local governing body, adapting to the demands of the farming community by continuing to use old counselling procedures (Noon 1949: 5). According to Noon (1949: 43), the perceived adequacy of these older judicial methods of coordinating reserve affairs throughout the 1800's was responsible for the late development of rule of law.

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[1] Of the total of fifty possible sachem positions, Chadwick (1897) reports thirty-nine occupied by Six Nations men in 1897 (p. 86-96). By 1958, Shimony (1961: 101-117) reported only twenty-six chieftainships occupied by Six Nations men.

The political position of Brant during the early years on the Grand River was somewhat unusual. His status as a war chief with the attendant power should ideally, in accordance with tradition, have terminated with the end of hostilities. Brant maintained his power after the revolution, however, largely by means of his influence with British authorities, and also because the continued threat of war with France and then with the United States prompted the Crown to carefully nurture its alliance with the Iroquois (Johnston 1964: lxx-lxxi).

Joseph Brant's unwavering policy of land sales was certainly in opposition to the Confederate Chiefs' traditional belief that land was not a commodity to be sold; however, the underlying issue concerned the source of political authority. After Brant's death in 1807 until at least the last quarter of the nineteenth century, this issue was largely unquestioned; political authority and power were allocated according to the principle of matrilineal descent. If there were no suitable candidate for chieftainship within a lineage owning a title, a non-lineage member was chosen. In some cases this investment was temporary, the title returning to the original lineage upon the death of the Chief; in others the recipient lineage claimed permanent right to the title. Thus confusion sometimes resulted over the choice of a particular candidate, but not over the basic principle of choice.

The Council of hereditary Chiefs formed the local governing body until 1924, when it was replaced by an elective system, an event bitterly remembered by some members of the Six Nations. The last thirty years of the hereditary system witnessed repeated efforts by the Chiefs to expand their jurisdiction and saw equally repetitive measures by the Indian Department to prevent this autonomous posture. With the change in the form of local government came greater cooperation with the federal administrators, and many changes on the reserve itself, such as the building of a permanent hospital.

Farming

Farming reached a high point of development on the reserve by the late 1800's and early 1900's. At that time there were several large farms that employed many men during the summer season, and a few that were maintained on a year-round basis. Farmsteads ranged in size from 100 to 300 acres: the land was used in varying proportions for cultivating grains of several kinds and for pasturing dairy and beef cattle. In addition, some farmers specialized in poultry, hogs, and sheep. Some farm produce was transported to the nearby markets in Hamilton, Hagersville, and Brantford, and the income therefrom was used to buy supplies for farm and home and to expand the farmstead.

The cooperation beyond the level of the family needed to sustain this economy was often effectively arranged by Council. Such things as the building of roads and bridges for transportation, the defining of boundaries with markers, the regulation of fence building, and the impounding of stray cattle, were controlled by the local government, largely through the development of special committees (Noon 1949: 44). Less formal, but more reciprocal patterns of cooperation were devised to meet such tasks as barn raising, stump removing, crop harvesting, and hay cutting and storage. "Bees," for example, became an established means of recruiting regular and specialized labour, particularly for erecting barns and houses.

Within the nuclear family a division of labour existed by which all members participated to varying degrees in maintaining the farm. The men regularly performed the bulk of the farm duties, especially the preparation of land for crops, but they were assisted in other tasks by their wives and children, and frequently by a grandparent. Women helped with the milking and poultry feeding and usually maintained their own vegetable gardens. The woman's role as cook was clearly defined: it involved not only the immediate preparation of food for the family table but also the feeding of the hired men during the summer and the preserving of vegetable products for the winter. At the local fairs, skill in the domestic arts of canning, baking, sewing, and quilting brought high acclaim for the industrious woman, and one with the reputation of being a "good cook" gained recognition from both men and women.

From the age of seven or eight children were required to take responsibility for certain chores around the house and barn, the responsibilities increasing as they grew older. The girls helped their mothers with the preparation of foods, housecleaning, washing, and sewing, and the boys carried wood and milk pails for their fathers and fed the stock. It was through this participation and parental guidance that the skills of farming and housekeeping were gradually learned.

Intense pride in obtaining a high quality of stock and grain and in ploughing skill was evident among both men and women at this early period. Six Nations success in competitions at their own and other local agricultural fairs, and at national and international ploughing matches served to justify this satisfaction in their own achievements. Moreover, the very nature of farming demanded individual enterprise on the part of the farmer, and this was in part responsible for the change in the basis of social recognition from inheritance to achievement.

The decline of farming as the main economic pattern began, informants say, with the trend to wage earning after the turn of the century and particularly during the Depression years. Farming today is not only "hard work" but also "big business," which necessitates large amounts of capital investment in equipment, buildings, and stock. Because of their Indian status, the nature of Indian land holdings (their land cannot be put up for security on loans obtained off the reserve), and other factors, loans are often difficult, if not impossible, for Indians to obtain. Furthermore, if money is available, there is a certain reluctance to invest to a high degree because of the likelihood that a market for selling to another Indian, if it exists at all, may be small, and the return on an investment may not be profitable. As a result there are today few full-time farmers on the reserve.

Despite the decline in importance of a farming economy, many men carry out farming activities on a part-time basis in addition to their main employment. Also, the farming-oriented associations, each of which was formed in the late 1800's at the height of reserve farming, are still functioning. The Ploughmen's Association, although reduced in membership, is still in existence, as is the well-attended Ohsweken Agricultural Society whose Fair Board produces the annual Fall Fair in late September. The Farmer's Institute, established later in the nineteenth century than the above association, used to hold an annual banquet in the community hall and throughout the year disseminate information on the latest farming techniques, largely through the mail. This provincial organization has now been replaced by a more extensive system of communication through a local Agricultural Representative responsible for a county-district. It is purely a matter of personal choice if this official is consulted by the farmer.

In 1905 the farmers' wives founded a branch of the Women's Institute that continues today as two separate branches.

The dispersed settlement pattern, part-time farming activities, and community associations with their agricultural base are the factors that give the reserve its rural character despite the dominance of wage labour as an economic pattern.

Education

In the late nineteenth and early twentieth centuries the Confederate Council undertook the building of public schools throughout the reserve. In 1923 there were eleven such schools staffed by both Indian and white teachers. Educational affairs in general were allocated to a School Board composed of five Chiefs, two whites, and the Indian Agent, through which financial assistance for school books and tuition for higher education could be obtained. Children who had been orphaned or abandoned have been sent since that time to the Mohawk Institute for care and education.

One of the primary concerns of the group agitating for a change in form of local government was the need for higher educational standards on the reserve. Soon after the elective system became operative, pressure was placed on the teachers to become properly qualified by the province if they did not already have the required certificates. Some of the Indian teachers who were not so qualified enrolled in Normal School to obtain this training, and others withdrew from teaching altogether. Inspection of schools by provincial officials was also initiated at that time.

Education beyond the public school level has never been available on the reserve, nor does there ever appear to have been a strong desire to build secondary schools there. This situation is partly the result of the problems of cost and staff and partly because of the general opinion of those who are concerned with education that children eventually must learn to "go outside" among the whites and that this is the most opportune time to begin.

Hence, in the early years of this century, sending children to high school required much determination and effort on the part of the parents. Even when they were highly motivated, and there was a small group of people who were intensely so, the problem of transportation presented a strong deterrent. If the children could not walk to high school (and many were too far from the schools) they had to be either transported by horse and buggy over roads sometimes impassible in the late fall and spring or boarded in the surrounding towns throughout the week, at additional expense to the family. Children whose parents did not value further education had a difficult struggle and often had to work for their room and board while attending school. Today these achievers are recognized as "self-made" persons and respected for their determination and "hard work."

This transportation problem has been greatly minimized by the building of good roads and the development of a school bus service for senior public school and high school students. Pupils are transported to the high schools in the surrounding towns of Brantford, Waterford, Hagersville, Caledonia, and Cayuga. If the need is demonstrated for this further education, they can, in addition, obtain assistance from the Indian Affairs Department under whose control Indian education has traditionally been placed.

At present there are twelve public schools on the reserve; the three newer ones and several additional rooms to the older schools have been built by the Indian Department. The great majority of teachers (76 per cent) are local Indians who qualified by training at various Ontario teachers' colleges. Some people feel that these Indian teachers are more suited to their positions than whites because "they understand the Indian mind." Others contend that it is, perhaps, naturally desirable for an Indian to want to teach in his own home area, but that one cannot designate the Indian way of thinking as different from that of the white man.

Prior to 1951 children attended the school in their own area from grade one to grade eight, often having the same teacher throughout these years. There are no kindergartens on the reserve. Since 1951, when Central School was built in Ohsweken, all grade seven and eight pupils on the reserve have been taken there by bus. This presented the first opportunity for children to meet others from the more distant parts of the reserve. More recently, specialized classes for slow learners and exceptional students permit the children to be taught according to their different abilities. A guidance counsellor has joined the Central School staff to assist the students in their transition from public school to high school or to some type of employment.

As a result of the differing attitudes toward formal education on the reserve, both between and within the conservative and non-conservative groups, and of the difficulty of obtaining high school education in the past, the great majority of adults have not attended school beyond grade eight.[2] A handful of adult men and women, either those whose parents encouraged them to obtain further schooling or those who were determined on their own to continue their education, have had high school and even some university training. Many of these individuals no longer live on the reserve, and thus provide justification for those who claim that "our ambitious people leave the reserve" because there are few opportunities for them to use their training there. Some of the Indian teachers have earned university degrees by working on a night school and summer session basis. In addition to the teaching profession, nursing has appealed to quite a few of the more acculturated girls, and they have become registered nurses and in recent years have become certified in the new role of nurses' assistants. The Lady Willingdon Hospital employs many of these women.

It is the young adults now raising families who are likely to have had from one to four years of secondary schooling.

Since the aspirations of many young people, particularly the males, are not toward clerical or professional work, formal schooling is not seen as an advantageous endeavour. Hence many boys desiring to earn money and (or) aspiring to become skilled in a trade leave school as soon as they are of age and their parents agree. Children of the elite families are encouraged to go on, are given praise for their scholastic achievements, and are generally free to take up whatever line of training and work they desire.

Contemporary economics

With the exception of the few people who operate stores, restaurants, and gas stations, or who teach, farm, or work in the hospital or for the Council either in its office or on the roads, most men are employed off the reserve. Since farming has declined and since there are no industries on the reserve itself to offer employment, the Six Nations men have little choice. This applies equally to the conservatives, despite the preachers' strong directives that Longhouse men should work "at home" (Shimony 1961: 14).

The jobs available to the men, who work as skilled and unskilled labourers,[3] include welding, mechanics, electronics, assembly-line work in factories, high steel construction, stone quarrying, and mining. Employment is available in the stone quarries and gypsum mines in the adjacent towns of Hagersville and Caledonia and requires only daily commuting. A small number of men are permanently employed in these mines and quarries, but more have had experience there at one time in their lives.

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[2] Hawthorn's report (1966: 103) claims that 2.8 per cent of the band population is educated past grade nine. This figure, however, should be cautiously treated, since reliable records were not available when these data were collected, nor are they presently available.

[3] Some indication of the various types of employment of the Six Nations Band members can be gained from the recent Hawthorn report (Canada 1966). These data, however, must be treated with extreme caution since those in the Agency at the time who were required to fill out the questionnaires were without sources of reliable information. Unlike areas such as education, religion, sex, and age, which either are surveyed regularly in the census or are available in band lists, the area of employment is not represented in Agency records.

The Hawthorn report pertains predominantly to males. Questions on types of female employment were not included in the questionnaires "except in those questionnaires which clearly specify jobs done by women; e.g., nurses" (1966: 38). According to this report the Six Nations worker is employed an average of 7.5 months of the year (1966: 49), with the period from December to February being the "critical months of seasonal idle capacity"

Many men commute daily to the surrounding towns, particularly Brantford, to work in food processing factories and farm machinery plants. A smaller number are employed in factory work in more distant towns and cities, especially in Hamilton in steel processing plants, and less frequently in Buffalo and Oakville in automobile manufacturing plants. Some of these men commute daily to their jobs, and a few board in these places and return home between shifts or on weekends.

Involving relatively long periods of absence for the worker from the reserve and requiring a more irregular commuting pattern, as locus of employment changes, is high steel construction work. Many more men have been "iron workers" at one stage in their lives than carry on the work permanently. As Freilich has noted among the Caughnawaga Mohawks, there is a great deal of pride in these men because of the danger and skill involved in their work (1958: 477-478). Admiration emanates not only from the men on the reserve but also from the women, particularly the wives of the iron workers, who usually volunteer information about their husbands' occupation. Some of these Six Nations men were employed in the construction of the Burlington Skyway and later the St. Catherines Skyway, which were relatively close to the reserve, but more often they had to travel to such cities as Hamilton, Toronto, Detroit, and Buffalo and to more distant places throughout Canada and the United States, where most of the construction is being done. As a result of the father's absence, especially from the spring through fall, greater responsibility is placed on the mother for the maintenance of the household and care of the children.

Duration of employment varies with the occupation, the degree of seniority, and the individual's working habits. It is not unusual to find a family situation in which the father has worked steadily throughout the summer and fall, and then has been laid off until the following spring. This applies more to the unskilled labourers than to the skilled; but for the skilled, although the wages earned during employment may be high (iron workers can earn as much as $600 a month when continuously employed), the income sometimes does not last or is not sufficient to stretch throughout the winter season. One woman whose husband was a truck driver claimed, for instance, that although her husband worked from 5:00 A.M. to 7:00 P.M. when there was a job available, they and their seven children would not have been able to get through the winter without applying for welfare assistance

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(1966: 91). The per capita income for the band is estimated at $350 annually (1966: 91) as compared to $1,400 for the average Canadian (1966: 45). The category representing the largest single percentage of workers is that termed "casual and unskilled labour" with 33.8 per cent (1966: 89). Skilled labour is the second ranking category, claiming 25.3 per cent of the workers. Food gathering (fruit picking) ranks third with 13.1 per cent of band members. In order of decreasing percentages are professionals (8.2), farm proprietors (7.0), non-farm proprietors (4.7), and clerical workers (2.0). It is worthwhile noting that among the thirty-five bands in the sample (including Tyendinaga and Caughnawaga) the Six Nations had the highest percentage of professionals; the band ranking second in this respect was Lorette (Hurons, near Quebec City) with 2.0 per cent involved in professional work.

were it not that he had unemployment insurance and credit from the local store.

The seasonal unemployment problem has been handled in a variety of ways. At the public school level the guidance counsellor attempts to impress upon the children the importance of continuing their education through high school to help ensure job security. The difficulty of obtaining a job sometimes causes a teenager to return to school.

A program of daytime and evening classes has been instituted on a provincial scale to upgrade the skills of persons through instruction in trades and clerical work, but few adults take advantage of this scheme. Recently, on a part-time basis, a liaison officer from the Indian Office in Brantford has been assisting individuals to obtain on-the-job training in a suitable line of work. The degree to which Six Nations people use these services is difficult to assess because of the newness of the programs.

A somewhat more successful approach has been taken on the reserve through the combined efforts of the local Council and the Welfare Officer. The Winter Works project, begun in 1961, provides a variety of jobs, such as wood chopping and brush clearing, by which men otherwise unemployed during winter earn their welfare monies. The measure of success is shown in the decrease of family units depending on unearned welfare from sixty-five units in the winter of 1961 to thirteen in 1965.

To augment the family income some Six Nations women work part-time or full-time, depending on their own initiative, their skills, and the ages of their children. During the summer, fruit and berry picking in the surrounding area and in the Niagara fruit belt, harvesting, and fruit and vegetable canning in local factories are popular sources of income. Although in the past years the women employed as pickers used to take their children with them to the "fruit country," today they leave them in the care of a grandparent or the oldest child. In some cases the older children accompany the mother.

In the past occupations of a professional nature have appealed more to non-conservative women than men; several women have become nurses and teachers, some of whom work on the reserve today. Throughout the years, the few men who did enter teaching, engineering, medicine, and law have in most cases left the reserve shortly after training and established themselves and their families in cities in both Canada and the United States.

The Longhouse and non-conservative people generally follow the same skilled and unskilled labour occupations. A notable exception, however, is that few conservatives became "big-time farmers" around the turn of the century, and few today enter the professions.

Religion

From the early 1800's to the turn of the century the ratio of Christian to Longhouse adherents gradually reversed to the present position of Christian predominance. In 1897, for example, 78.3 per cent of the band members were Christian, and 21.7 per cent were Longhouse (Canada 1898: 353). In 1959, 79.8 per cent of the band claimed Christian affiliation, 19.1 per cent were Longhouse, and 1.14 per cent were "not stated" (Canada 1961: 16).

According to the 1959 census (Canada 1961: 16) the religious affiliations of the Christian band members were as follows: Anglican 34.99 per cent, Baptist 29.83 per cent, United Church 8.50 per cent, Presbyterian 1.41 per cent, Roman Catholic 1.25 per cent, others 3.79 per cent. Longhouse adherents constituted 19.07 per cent of the band, and 1.13 per cent had no affiliation.

Of the four longhouses on the reserve—Lower Cayuga, Seneca, Onondaga, and Upper Cayuga—the first three are located "down below," that is, in the northeastern portion of the reserve where a great many of the adherents live. The designation "down below" originated from the initial distribution of tribes along the Grand River when the nucleus of Handsome Lake followers occupied land "down river." But tribal membership is no longer an indication of religious affiliation. Anglican, Baptist, and United Church denominations have been established on the reserve since the mid-nineteenth century; Mormon, Jehovah's Witnesses, Pentecostal, and a few small missions are more recent additions. A special pride of the Iroquois has been the Mohawk Chapel, the church promised them by Haldimand, with its prized Silver Plate donated by Queen Anne. It was built by Brant and his friends in the years immediately following settlement on the Grand and is now a major tourist attraction in the Brantford area.

Today each of these sects has a resident minister, and the Anglican, United, Baptist, and Pentecostal churches each has more than one church building. In spite of their long establishment, the churches are not well attended in relation to the professed Christian population. To varying degrees, the ministers have participated in the community life of the reserve, and those who have taken a leadership role in athletics for youths and "teen town" organizations are particularly respected.

Women's groups such as the Women's Guild or the Ladies' Aid formed within church membership have become a regular part of the conscientious churchgoer's social life. Their activities have traditionally included sewing and quilting bees, fund-raising through such enterprises as home cooking and rummage sales, and catering for local banquets on and off the reserve. Monies obtained are used for additions to church buildings, new equipment, choir gowns, and so on. Taking baskets of food to the sick and aged, especially at Christmas time, has become an established part of their community service. Recently, craft skills have been taught within this framework, as well as through the Women's Institutes, and other craft groups on the reserve.

There is certainly no overt conflict between the Christian and Longhouse religious systems on the reserve. Efforts to Christianize the Longhouse adherents have long been abandoned. But it is the difference in religious belief, even if affiliation is by lip service only, that determines participation in either the conservative or the non-conservative pattern of reserve life.

Politics

During the late 1800's and early 1900's, several new offices, committees, and boards were added to the structure of the Confederacy to cope with the new demands of reserve life (Noon 1949: 53). One of these, the

Board of Health, created by the Six Nations' Public Health Act of 1900 (Canada 1900) is of particular concern to this thesis and will be discussed at length in chapter four.

The greatest single change in the form of local government came in 1924, when the Confederacy was replaced by an elective system. Several years prior to this date discontent with the hereditary system had arisen among certain portions of the population, particularly the non-conservative. One factor behind this dissatisfaction was the gradual shift from ascription to achievement and wealth as a basis for status and power (Noon 1949: 27). Furthermore, the new emphasis on education for holding office undermined respect for those chiefs who lacked formal schooling.

One of the most fundamental issues, however, was religion. A division among the Chiefs themselves into Christian and Longhouse 'parties' made decisions steadily more difficult for the Council and rendered impossible the ideal of unanimity (Noon 1949: 45). Although attempts were made repeatedly to remove this religious conflict from political matters, none was successful.

In very general terms, and with a few definite exceptions, the Longhouse adherents came to represent the anti-change pro-Confederacy "party," and the Christians the pro-change anti-Confederacy "party." Formally organized political parties have never developed, however, along these or any other lines.

Despite the sometimes faltering allegiance of a few members, a group of "progressives" called the Warriors' Association, or the "Dehorners," was promoting with determination the removal of the hereditary Chiefs. The title "Dehorners" derives from the warriors' aim of removing the "horns of office" from the Chiefs, whose authority was symbolized in a particular type of head-piece. This group, formed in the last quarter of the nineteenth century, consisted of those men who had accumulated a certain amount of wealth and had experienced considerable contact with Europeans (Noon 1949: 48-49). The attitude of this group toward hereditary authority and the bases for responsible leadership, as well as the zeal of the movement, is clearly illustrated in the poem written by Nelson Moses, an ardent Dehorner, and published in a Caledonia newspaper, *The Haldimand Banner* on February 27, 1908. (*see* p. 26).

In keeping with their progressive outlook, the Warriors agitated for the establishment of bylaws in Council procedure, for better educational facilities and standards on the reserve, and for the right of the individual to become enfranchised. The degree to which they were responsible for the final changeover in government remains to be assessed. One fact is certain, though: the expectations of those promoting an elective system were disappointed.

Although it represented an old political ideology, a group known as the Mohawk Workers, opposite in goals to the Warriors' Association, was formed later in the century. Membership, which was not limited to Mohawks, included predominantly Christians, with some Longhouse adherents. With determination equal to that of their opponents, the Mohawk Workers promoted the continuance of the Confederacy, emphasizing its sovereignty as a political entity and resisting changes perceived to threaten this status.

To the Chiefs

I

Ye rusty Chiefs all born that way
Your grannies say, you must obey
Altho' they think you know so much
Don't fool yourselves you're but a bautch.

II

Once a month they gather round
With symptoms deep and looks profound
Few learned Chiefs, run o'er the business
While others sit as witnesses.

III

Seventy Chiefs! Just think of them
How like the ancient Sanhedrin
Like mud on wheels, that clog the speed
Please Sir Oliver, a change we need.

IV

The rusty Chiefs, no judgement have
Who sit they there in whose behalf?
For granny's choice, and granny's pride
Rules a nation, "unsatisfied."

V

Twelve thousand Dollars every year
Thousand a month, 'tis very clear
They signed for more, but all the same
The Department they did shame.

VI

Their sons shall take their places soon
It matters not how near a loon
Ah! what use is education?
For ignorance rules this Reservation.

VII

We long to see their places filled
With men of judgement and self-willed
Men who love civilization
Progressive things for the Nation.

VIII

The time is come, the change is near
Warriors brave—you must not fear
Strike for your rights and rest you not
Strike sir! while the iron is hot.

IX

Go back ye Chiefs to your grandmas
For your advice and for your cause
Can you not hear the tocsin knell
Pealing forth sadly the Chief's farewell

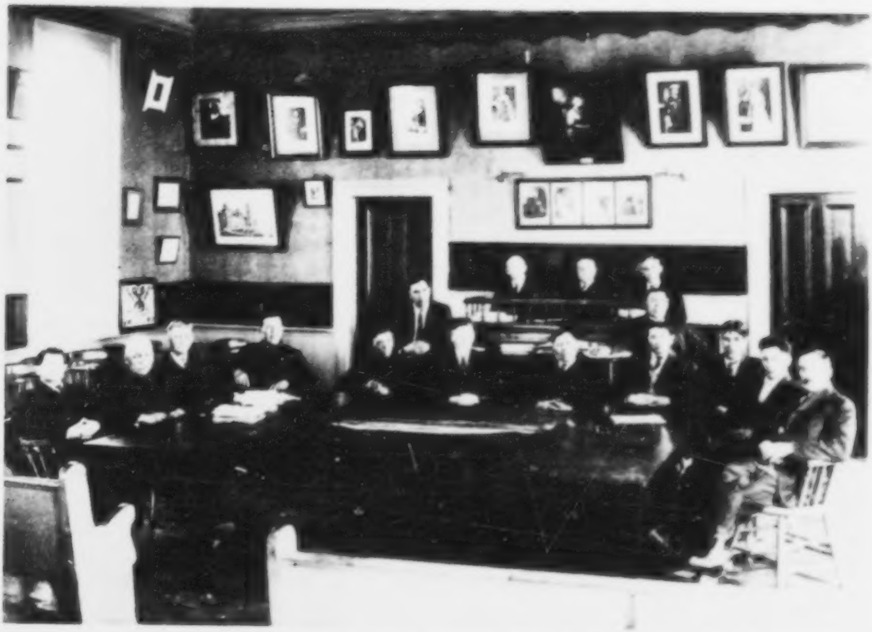

Plate III. First elected Council, 1924. Seated at back, L to R: Unknown, Col. C. E. Morgan, Superintendent, Hilton M. Hill, Chief Councillor. Seated at Secretary's desk, L to R: Frank W. Montour, William F. Powless (Secretary). Seated at tables, L to R: Pat Sero, David General, William Smith II, George Garlow, John Anderson, Archie Russell, William Staats, Wilbur Monture, Joseph F. Hill, Jim Davis, Frank Miller. (Courtesy Mrs. Hilton M. Hill.)

Although the degree to which the supporters of the two divergent positions on the future course of reserve life actually constituted formal groups has never been clarified in the literature, these groups were none the less significant. The two extreme poles of opinion on acculturation were current in 1923 when the Canadian Government appointed a Commissioner, Lieutenant-Colonel Andrew T. Thompson, to investigate the "affairs of the Six Nations Indians, including matters relating to education, health, morality, election of chiefs, powers assumed by council, administration of justice, soldiers settlement and any other matters affecting the management, life and progress of the said Indians" (Thompson 1924). By this time procedures in Council were highly charged with emotion. The Chiefs were aware of the Government's desire to establish an elective system of reserve government and, as a result of the ill-feelings, communication between them and the Indian Agent became minimal.

The result of the federal investigation was a Parliamentary Order-in-Council dated September 17, 1924, dissolving the hereditary system, outlining the structure of an elective system, and ordering the first election to be held in October 1924. During that September's Council meeting the Royal Canadian Mounted Police, posted on the reserve in anticipation of some opposition to the change, locked the doors of the Council House during lunch break to prevent the Chiefs' returning to the chamber. This action signified the end of federal recognition of the Confederacy's right to rule the Six Nations reserve.

The indignity and coercion of the incident have been neither forgotten nor forgiven by the conservatives, the Mohawk Workers, and many others with similar but perhaps less extreme political leanings.

The Order-in-Council of 1924 divided the reserve into six electoral districts. From each, two Councillors were to be elected to office for a one-year term. In 1951 a further Order-in-Council restated this formal procedure of the elective system and added that a Chief of the band having a two-year tenure of office was to be elected by members of all six districts. A Chief Councillor had presided over the Council meetings since 1924, but until 1951 he had been elected by the Councillors themselves.

At present, on the first Thursday of each month, the twelve Councillors and the Chief assemble at the Council House in Ohsweken with the Indian Agent or another federal representative. The agenda is prepared in advance by the Assistant Secretary of the Council, and the proceedings are directed by the Chief. Over the years, matters requiring considerable attention have been systematically allotted to formal committees to be dealt with at separate sessions. The resulting decisions are then reported to the Council in regular session.

Elections are held at two-year intervals in December, and only those persons legally defined as members of the Six Nations, that is, those enrolled on the band list, are entitled to vote. According to Agency personnel only a small number of non-residents return at election time to cast their ballots. The percentage of actual voters compared to the possible resident voters has varied over the years from 24 per cent to 41 per cent (Agency File, Six Nations Elections). Noon's (1949:65) statement that the 10 per cent voting in the first election has remained relatively constant is incorrect. In recent elections of 1963 and 1965, for example, 31.6 per cent and 30.2 per cent of the eligible electorate voted. This moderate turnout can be attributed to several factors, particularly the refusal of conservatives, Mohawk Workers, and those with similar views to recognize the elective system as a proper governing body, and the belief and fear that their Indian rights will be forfeited if they do vote. Moreover, some non-participation is undoubtedly because of a general lack of interest in political matters.

These same reasons for not exercising the local franchise apply to the non-participation in provincial and federal elections. In June of 1955 and 1962 the Six Nations voted, for the first time in many years[4] in provincial and federal elections, respectively, without being enfranchised, i.e., losing their legal status as Indians (Canada 1957, section 109). Those who do vote in these external elections are the more acculturated individuals, oriented more to the "outside" and interested in politics *per se*.

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[4] It should be noted that the right to vote had been extended in 1885 to include male Indians resident on reserves and did not involve the loss of their legal status. In 1898 this franchise was withdrawn and remained so until 1954 (Statutes of Ontario 1954, C25, S4(1)) and 1960 (Montgomery 1965: 13), respectively, for provincial and federal elections.

Many of these individuals have quite definite ideas about the established political parties and their leaders.

Contemporary views on internal politics are discussed in the following chapter since an understanding of such opinions and attitudes is made clearer within the framework of conservative and non-conservative patterns.

Chapter II

Characterizations of the Conservative and Non-Conservative Sociocultural Patterns

At present it would be unwarranted to project the current distinction between conservative and non-conservative sociocultural patterns into the past to describe the situation of the Six Nations after resettlement in the Grand River Valley. Although, as already noted, no ethnological attention has been given to the history of these two patterns, the existence during the early 1800's of a division along religious lines in some Iroquoian communities in New York State has been established (Deardorff 1951). That this division was soon evident among the Grand River Iroquois during the early period of resettling is illustrated by the following observations of the Reverend Samuel Kirkland.

> In the autumn of 1798 a young Mohawk Indian of Grand River, fell into a kind of *trance* for 24 hours or more. In the conference which this young Indian had with the *Upholder of the Skies,* the latter made grievous complaints of the base and ungrateful neglect of the Five Nations (the Senekas excepted) in withholding the homage due to him and the offering he was wont to receive from their fathers, as an acknowledgement for his guardianship. Many were the evils which had come upon them in consequence of this neglect. Sickness, epidemic disorders, losses in war, unfruitful seasons, scanty crops—unpleasant days. The character of this young man was so unblemished and remarkable for a sedate and reflecting mind, that when he declared his vision in a serious and affecting manner, it immediately gained almost universal credit in the settlement. [Joseph] Brant, from political motives, found himself obliged to give his consent to a sacrifice and offering to the *Upholder of the Sky,* with this condition, that should not be considered as setting aside the christian religion. The sacrafice [sic] with all its appendages was performed—Christian and Pagan all attended, tho none but the Pagans partook of the feast. It seemed to diffuse new and general joy throughout the whole settlement (Johnston 1964: 242).

Apparently both reinforcing and cross-cutting this religious division were differences of opinion among the Iroquois over Brant's political authority as against that of the Confederate Chiefs and his right to divest the people of their land; the Lower Mohawk Chiefs supported rule by Chiefs and disclaimed Brant's authority, and the Upper Mohawks aligned themselves with Brant (Johnston 1964: 54-55, 297). But the extent to which these differing beliefs may actually have led to dissociation between Christian and non-Christian groups is at present difficult to assess from the scarcity of published material.

In contrast, there are today two deeply entrenched sociocultural patterns on the Six Nations Reserve: the conservative and the non-conservative. The Iroquois define the groups in terms of religious affiliation, as "Longhouse people" and "church people" respectively. Among the older generation church people, the conservatives were, and in some cases still are, referred to as pagans, but this term is no longer popular among the younger generation and indeed is seldom heard. The church people now consider the term "pagan" improper, because the Longhouse "do believe in God," and hesitate to voice it because it implies "disrespect," as several informants described it, for the tenets of their fellow Indians. That the term "pagan" was disliked by the Longhouse people is evident from measures taken by the Confederate Chiefs in Council on August 5, 1908, when the following resolution was passed:

> The Council decided that hereafter the word "Pagan" shall not be used in referring to any of our people hitherto known as Pagans of the Six Nations, as it is a misnomer, as according to their peculiar belief they are "Deists" and not Pagans and that hereafter they shall be known as "Deists" (Minutes, 1908-1910: 73).

Although the term "Deists" is occasionally used, it has never gained popular acceptance. But the desire to eliminate the term "pagan" has been gradually realized by adopting the term "Longhouse," a less derogatory one in connotation from both points of reference.

Despite the fact that the Six Nations people "align and realign on almost every conceivable level" (Shimony 1961: 12), this differentiation of conservative and non-conservative groups constitutes the most deep-seated social cleavage on the reserve. As Shimony claims, "there are practically two distinct cultures at Six Nations, and the distinction between them is clear-cut and obvious" (1961: 15).

Recognizing an individual as a conservative or a non-conservative is not possible on the basis of physical appearance, dress, material possessions, or, in most cases, occupation. Nor does location of residence in a particular part of the reserve give any indication, with the exception that those living "down below" are most likely to be Longhouse. As for language, the majority[1] of Six Nations who "talk Indian" are conservatives and all but a very few speak English as well. Of the small number of non-conservatives who do understand or speak any of the six Iroquoian dialects (Delaware, an Algonkian language, is not spoken on the Six Nations Reserve today), most of them are of the older generation. Hence the allocation of an individual to one group or the other on the basis of these overt traits is impossible in the majority of instances.

It is more in the realm of covert traits, beliefs, attitudes, values, and associations, that this distinction appears, but it is not based merely on religious differences, as the native designations would suggest; many students have realized this in the past (Rioux 1952: 94; Fenton 1965: 262; and Nicholas 1965: 50). Nor do the Iroquois limit their perception of these categories entirely to the religious sphere, although this aspect has traditionally been the most central feature and the most obvious criterion.

The conservatives have been characterized as follows:

> It is possible, however, to identify without undue arbitrariness, the group which carries on the Iroquois tradition. It consists of those individuals who share allegiances and characteristics as follows: in religion they adhere to the Longhouse; in politics they uphold or advocate the hereditary chieftainships; in kinship matters they count descent matrilineally and recognize clan and moiety affiliation; they reside primarily on the Reserve; and, while willing to accept some white material traits, they are consciously opposed to acculturation in regard to their philosophy of life. This group strongly desires to remain Indian and attaches a superior value to Indian ways and mores (Shimony 1961: 12, 14).

Culturally the non-conservatives do not have a pivotal social institution similar to the conservatives' longhouse. Thus it is not surprising that the non-conservatives hold beliefs and attitudes as well as allegiances that are marked by a great degree of heterogeneity. In contrast to the diversity of beliefs, opinions, and outlook on life in general is the restriction of social interaction to members of the non-conservative group who hold similar views (*see* chapter five for discussion of sub-groups). The inconsistency between ideal and practice within the more acculturated group does not, however, cloud over the fundamental features that the members of the group have in common and that serve to distinguish non-conservatives from conservatives.

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[1] A Community Appraisal Report of 1961 of the Department of National Health and Welfare estimated that five per cent of the population spoke Indian dialects.

Although the non-conservatives are nominally Christians, in reality, though many reinforce this claim by holding membership in one of the many churches, only a very small number actively participate in church affairs. The existence, furthermore, of several denominations and churches of the same denomination has made for a moderate degree of social segmentation, more so during the early part of the century than at present. Although most non-conservatives attend Sunday school at some time during childhood, interest dwindles after adolescence if not before, and parents tend to send their children to church rather than to accompany them. Parents feel an obligation to expose their children to religious instruction, but few parents actually participate.

In politics there is by no means an overall non-conservative allegiance to, or support of, the elected Council. Despite the introduction of the new system of government, their political views today are essentially the same ones they held in the 1920's, with perhaps the exception of the so-called "Progressives" who could no longer be said to form any sort of group. Political opinions vary from one extreme to the other and pivot on several critical and related issues: the form of reserve government, the reserve system, the status and rights of Indians, and the attitudes towards the Federal Government. Because these clusterings of opinion on the issues mentioned above do *not* correspond to the non-conservative subgroupings to be outlined in chapter five, they will be discussed here to the extent necessary to provide a total picture of the non-conservative pattern and an adequate background for understanding the recent medical problems on the reserve.

Politics, a topic of deep concern to the non-conservatives, is discussed freely and seldom without emotion. Those non-conservatives who have taken extreme stands on the important issues are locally referred to by specific labels that tend to give the impression of group distinctiveness where it does not exist. At the one pole are those called Mohawk Workers, and at the other those called Progressives. There is no local term to describe those who hold opinions at mid-range on the continuum.

To discuss these political opinions in terms of conservative and progressive only is, however, misleading because it gives the deceiving impression that the non-conservatives generally hold Progressive beliefs. My definition of the term "Progressive," essentially the same as that used by the Six Nations, is the favouring of reform toward a new model. As such, the designation "Progressive" by no means applies to the political views of the bulk of the non-conservatives. Hence, in referring to the more acculturated group of Six Nations *vis-à-vis* the Longhouse group, the term non-conservative was chosen, simply to prevent the implication that reform *per se* represents a pervasive or general ideal of the non-conservatives.

Individuals referred to as "Mohawk Workers" occupy one end of the continuum of political thought recognized by non-conservative people on the reserve. This term, however, is applied loosely to designate both those who seek to reinstate the hereditary system of government and prevent unwarranted (Federal) Government interference in reserve affairs and those who simply are "agin the government" (Federal) but do not desire the return of the Confederacy. Despite this inconsistent usage, it is generally agreed that those who aspire to return the Confederate Chiefs to power are the "real" or "true" Mohawk Workers.

Further confusing the issue is the fact that this term "Mohawk Worker" is occasionally applied to Longhouse adherents who support the hereditary system. But in the usual frame of reference, the few Longhouse adherents who are considered "true" Mohawk Workers are so labelled because of their more verbal and aggressive behaviour in actively seeking to reinstate the Confederate model of government. With the one exception of politics, however, the Mohawk Workers share little in common with the conservatives. The Mohawk Workers are non-conservatives and are considered "church people" by the Longhouse people.

Since the 1920's the Mohawk Workers (and certain Longhouse Chiefs) have relentlessly tried to obtain official recognition of the Six Nations as an autonomous state and to re-establish the Confederacy. The tenacity of their beliefs was manifested in March of 1959 when an abortive "revolution" was organized with the intent of terminating the elective system of government on the reserve. During the summer of 1965 efforts were still being made to raise funds to retain a lawyer from New York City to plead their case for autonomy before the United Nations.

Recourse to legal advice and organizations outside Canada is by no means a new approach for the pro-Confederates. As early as 1923 a small group of Chiefs with Six Nations passports travelled to Geneva to present their case to the League of Nations. In spite of the able assistance they received from a Rochester lawyer, the delegations gained little satisfaction; they were informed that their claims would have to be presented to the Canadian Government, which has had control over Indian affairs since Confederation (Montgomery 1963: 100).

The Indian rights, which the Mohawk Workers are so ardent and so verbally aggressive in propounding and defending, are derived from a variety of sources: treaties and deeds with the contact culture, custom law based on the continued existence of certain practices of the Canadian Government, and the Indian Act. Their claim to sovereignty as a state is rooted in their past alliance with Great Britain and the use of the word "allies" in reference to the Iroquois in various agreements and deeds with the Crown. The right to freedom from taxation on their reserve lands and improvements, on estate transactions, and on income derived from the reserve; the right to maintain their reserve lands for Indians only and to remove non-Indians; and the right to receive annuities from band funds are frequently and often bitterly mentioned in conversation, and all have their basis in the Indian Act. One right based on long-standing practice of the Canadian Government, that of receiving free medical assistance, is critical to this study and will be dealt with in a later chapter.

The prevailing attitude of the Mohawk Worker toward the Federal Government is one of deep antipathy based on long-remembered injustices to the Iroquois, particularly the loss of their lands and the removal of their Confederacy from power in 1924. They oppose the intervention of the Federal Government (and lately of the Ontario Government because it enforced the sales tax on cigarettes sold on the reserve) in some reserve affairs and at the same time criticize its lack of responsibility in others. This ambivalence is nowhere more apparent than in medical matters.

Whether the "real" Mohawk Workers actually constitute a formally organized group whose members work together towards shared goals is a question with which this study is not immediately concerned. It is apparent that sustained resistance activities are very tenuous, and that, with the exception of the secretary, there are no formally recognized offices. The Mohawk Workers' most obvious pattern of collective activity is their direct, almost reflex, reaction to outside pressure that seems to threaten their Indian rights. This pressure is usually that stemming from a governmental source, either provincial or federal. The Mohawk Workers have recently evidenced this reaction by arranging public meetings with Indian speakers, by circulating correspondence received from government officials or lawyers related to their "cause," and by raising funds to finance a lawyer to handle their "case." It appears that when the issue of the moment is perceived as "won," as it was in the tobacco sales tax crisis early in 1966, the temporary cooperative effort disintegrates. This same collection of individuals will no doubt join forces again in the future with similar provocation.

At the opposite end of the continuum of political opinion are the Progressives, but those who publicly acknowledge themselves as such are very few in number. They are as concerned with the status and rights of the Indians as the Mohawk Workers, but they contend that the rights embodied in the Indian Act are neither desirable for nor beneficial to the Iroquois. They consider the Indian Act a legal means of creating and maintaining the Indian's status as an inferior or second-class citizen, and the reserve system a strong deterrent of individual initiative and responsibility. The legal status of Indian land holdings and improvements they see as seriously inhibiting economic development and causing many of the enterprising young men and women to leave the reserve. Their attitude toward the Federal Government is not one of embitterment, but of moderate resentment at its retaining these restrictions on the Indian; their goal is to see the Indian Act changed or, preferably, abrogated. This would necessarily involve the dissolution of the reserve *system*, an event that is considered inevitable and highly desirable.

The majority of the non-conservatives hold political opinions scattered along the continuum between these two extremes, and most of them desire the continuation of the present reserve system. This status quo middle group are equally aware of past injustices, or "raw deals," but they neither dwell on these grievances nor condemn the present generation of whites for perpetrating them. There is a wish to maintain the Indian rights as they are and a certain nostalgia for the past glory of the Confederacy that in some cases may reach the intensity of desiring the return of the old Chiefs. The moderates rather unhappily foresee the inevitable demise of the reserve system and their subsequent loss of certain rights, but some anticipate the gain of new rights, particularly those connected with land holdings and investments. Unlike the majority of Mohawk Workers, these individuals and the Progressives vote in the local Council elections. It is evident from this brief sketch that the diversity of political views renders general statements regarding this aspect of non-conservative life very precarious.

In the non-conservative kinship pattern the basic social and economic unit is the nuclear family, and descent is traced bilaterally. Newly married couples, free to choose their place of residence, in most cases tend to build near the home of one set of parents, usually because land is given or is available to them.

Although clan affiliations may be remembered in a few instances, neither the clan nor the moiety has any function in the non-conservative pattern. The most immediate relations within the bilateral kindred provide assistance in times of need and crisis. Among some families, these relatives get together for periodic family reunions and thus renew bonds that are often not active because of off-reserve residence.

The social life of the non-conservative individual revolves not only around kinship ties but also around friendship ties and does not pivot on religious matters, as is the case among the conservatives. Again unlike the conservative pattern, there are few if any deterrents to participation in voluntary associations derived from Euro-American culture. The non-conservatives have established many such groups in the past: for example, the Temperance Society, the Christian Aid Society, the Benevolent Societies (these three have diminished in activity in the past ten to fifteen years), Alcoholics Anonymous, the Ploughmen's Association, the Agricultural Society, the Women's Institutes, youth organizations such as Brownies and Guides, and Young People's groups affiliated with the churches. In these associations (except the first four) integration is achieved largely through the extensive overlap of personnel, not because of any common connection with a focal institution such as the Longhouse. Furthermore, participation in these groups is according to the individual's interest and to the feelings of obligation to contribute time and energy to these community affairs. Belief in doing one's part guides this participation rather than an anxiety that personal health will suffer, as is the motivation among the conservatives (Shimony 1961: 261). Once membership is established, all that can suffer is one's reputation if duties are reneged without due cause.

The personnel overlap among these voluntary associations of the non-conservatives is, however, both the strength and the weakness of collective life. The small recruitment of members is a weakness that places a heavy burden on a few and sometimes creates internal discord when tasks are uncompleted or unsatisfactorily performed. Once commitment is made to this group of community-minded individuals, regular attendance at meetings is almost mandatory, unless illness or family responsibilities legitimately prevent it. Failure to appear brings such comments as "He should have been there; he knew it was important," and "What's wrong with her; why wasn't she there?" Furthermore, if members repeatedly violate the norm of avoiding friction in interpersonal relationships at meetings by making personal attacks upon individuals, the disapproval is expressed after the meeting in conversation among the members. Questions then arise as to the motives behind such inappropriate, aggressive behaviour. A similar ideal of interpersonal relations is upheld by the politicians, who term it "diplomatic." But in both arenas of activity (i.e., politics and civic affairs) and in interaction between them, the existence of those who continually break this norm tends to unite the other members in disapproval and cooperation. This counter-balancing union in disagreement is the strength that results from personnel overlap.

In the residence practices of the non-conservatives there is no stress placed on living on the reserve. In fact, many families have at one time established residence off the reserve for long periods. These families returned not because of any cultural dictate as to where one should live, but because of the fact that it is "home." Nor is there any ideal that one should derive one's income from working on the reserve. Employment there is handy but not imperative in their evaluation and often impossible.

The material aspects of the contact culture are highly desired by the non-conservatives, and purchasing is limited only by income, spending patterns, and personal taste. There is keen interest in the newest food products, dress styles, household appliances, furnishings, automobiles, and farm equipment, whether or not the individuals or families can afford to purchase the articles.

Finally, the non-conservatives, like the conservatives, place great value on being and remaining Indian, despite their considerable integration with the contact culture. This, however, does not mean maintaining a traditionally Iroquois way of life: they want the freedom to choose change in any aspect of their lives *if* they so desire and, with the exception of the Progressives, they want the freedom to maintain the reserve as a reserve with all their Indian rights intact.

The non-conservatives are proud of being Iroquois and Indian. Those interviewed indicated that they identify primarily as Indians, not as Canadians: most view any perceived threat to their Indian status with great anxiety. There is fear and suspicion on the part of many that this status will be abrogated by forces beyond their control, such as band enfranchisement, which, under section 112 of the Indian Act, could occur without band consent at the discretion of the Minister.

It has been claimed that the non-conservatives tend to be more assertive than the conservatives in their general behaviour (Rioux 1951: 158). I have found this to be particularly evident in their voiced determination to maintain their status with its desired prerogatives. Inasmuch as the non-conservatives have retained very little of traditional Iroquois culture, and because they have such an intense concern for their legal status with its attendant rights, the term "consciously" Indian seems very apt in describing their Indianness. Rioux (1952: 97) uses this label in a conservative or "native" (terminology of Voget 1951) frame of reference in distinguishing the type of native orientation of the "traditionally native" Lower Cayuga Longhouse members from the "consciously native" Onondaga Longhouse members. However, I feel the term "consciously" equally highlights the difference between the conservatives and non-conservatives. With this usage, the conservatives would be termed "traditionally" Indian.

Without denying the non-conservatives' desire and determination to maintain their Indian status and identity, this group could be classified in Voget's terms as American-modified according to the following description:

> Members of the *American-modified* category still thought of themselves as Indians and with some notable exceptions, maintained a limited social participation with the native-modified group, but their cultural integration basically was in terms of that of the dominant American society. Moreover, some members of this group manifested strong tendencies to participate in white society on a basis of equality (1951: 221). [Italics the author's]

Voget's category of native-modified could be applied to the Longhouse adherents. He describes this group as being "nativistic in orientation, but their formal education within the dominant society together with a limited participation in segments of American culture had led them to support modifications of native institutions and to inject new meanings, into 'native' ceremonial forms" (1951: 221). It should be noted, however, that the application of the term "American-modified" to the non-conservative group is somewhat misleading. The confusion stems from the fact that while the summary of the American-modified category given above does describe the non-conservatives as a whole, the substantive description he presents for the Christian portion of his native-modified category equally aptly describes in particular the political attitudes (i.e., antipathy toward the Federal Government and desire to retain the reserve) of many non-conservatives, and Mohawk Workers in particular. This loose application of Voget's terminology to the Six Nations again serves to highlight the fact, as mentioned elsewhere, that political opinions cross-cut the conservative-non-conservative dichotomy. Moreover, within the non-conservative category political opinions similarly cross-cut status groupings.

Finally, on the basis of the lack of cultural dissimilarity between Canadian and non-conservative culture, rather than on the basis of an imputed low identity commitment to their ethnic group, I would agree with Randle's statement that:

> Today the people of the Six Nations participate to a large extent in the surrounding Ontario culture, some individuals participating so completely that their identification with the Indian group seems nothing more than a sentimental gesture (1951: 174).

Chapter III

History of Medical Services, 1850-1950

The historical perspective to be dealt with in this chapter spans the years 1850 to 1950. Information on the pre-1850 period (1784-1850) is derived from secondary sources, and will be presented in cursory form only. The year 1950 marked the end of an era in which medical treatment was predominantly seen by the Six Nations in terms of a person, the physician, and the beginning of a period in which treatment was seen in terms of a place, the hospital, with less personalized attention. This transition point in medical services was more abrupt than those of preceding years, and was followed by the rapid introduction of several medical innovations. The effects of the 1945 transfer of responsibility for Indian health from Indian Affairs administration to the Department of National Health and Welfare became evident in the reorganization of the reserve hospital. The impact of changes that had occurred within the medical institution itself was then intensely felt by the Six Nations, and particularly the non-conservatives.

To emphasize this 1950 turning point is not to deny that many fundamental changes in medical affairs on the reserve occurred between 1784 and 1950. The critical factor in the earlier medical innovations is that there was a thread of continuity throughout the changes—the physician's country-doctor role—which, despite changes in medical technology and therapeutic setting, tended to provide a certain degree of stability.

On the basis of the type of medical assistance immediately available to the Six Nations and, more significantly, their reaction to and participation in these facilities from 1784 to 1950, four periods, or contact models, can be distinguished. The fifth period, from 1950 to 1966, will be discussed in the next chapter. These five periods are as follows:

(1)	1784-1850	Itinerant physicians
(2)	1850-1900	Resident physicians
(3)	1900-1927	Physicians aided by temporary hospital and local board of health
(4)	1927-1950	Physicians working in hospital context, but maintaining a country-doctor role
(5)	1950-1966	Physicians working primarily in hospital and using a team approach to medicine

The pre-1850 period

Since published materials offer scant information for this period, only a cursory and very tentative picture can be drawn at present.

The earliest indication that medical assistance was being rendered the newly settled Six Nations appeared in the first decade of the nineteenth century (Johnston 1964: 110). A military surgeon named Robert Kerr was employed by the colonial government to attend to the medical needs of the scattered tribal settlements along the Grand River. After Kerr's death in 1824, this responsibility—which must have been formidable because of the dispersed population and the limitations of transportation by horseback—was given to several physicians in the surrounding towns. It soon became evident that even this recourse to local physicians was not so workable as desired.

The New England Company, which had established its first representative in the valley in 1828, also assumed an interest in the physical and spiritual well-being of the Six Nations. Despite all these good intentions, however, the subsequent medical arrangements were not considered adequate. This dissatisfaction was apparent in a letter from Sir George Arthur, then Lieutenant Governor of Upper Canada, to the New England Company in 1838.

> On my Way up the Grand River I visited some Indian Families, and found them suffering from Fever and Ague, without the Prospect of Medical Advice. Upon Inquiry I learned that Disease had made great Ravages amongst them, and I have therefore given Directions that a Physician be immediately appointed, whose Time and Attention shall be exclusively devoted to the Indians along the Grand River. You will be pleased to inform the Indians that this Want is supplied (Johnston 1964: 299).

In response to Arthur's appraisal of the situation, the treasurer of the New England Company later informed Sir George Grey, past under-secretary for the Colonies (1834-1835), of the difficulties involved in obtaining satisfactory medical services for the Six Nations.

> The Number of Indian Inhabitants on the lower Part of the Grand River has lately considerably decreased, owing to the Dams across the Grand River, for the Purpose of improving the Navigation, having flooded to a considerable Extent the bordering Lands, and introduced Agues and Fevers into Situations formerly healthy.
>
> I must not omit to mention the Participation of the Committee in the Feelings of Gratitude which the Indians must entertain towards Sir G. Arthur for his judicious Kindness in the Arrangement he has made for supplying them with Medical Advice. The New England Company have heretofore paid considerable Sums for this Purpose, but it was found not easy to get the Indians to apply for Prescriptions at a sufficiently early Stage of their Disorders, nor could the prompt and punctual Attendance of the Gentlemen then practising in the Neighbourhood be always relied on. The Influence of Government, it is to be hoped, may overcome these Difficulties (Johnston 1964: 301).

With the few existing published sources, it is difficult to determine whether the Iroquois of the 1830's considered Western medical technology desirable, and whether they actually requested the services granted by Sir George Arthur. By 1843, however, some Chiefs were desirous of obtaining a resident physician and even approached a doctor who was willing to resume his practice in the service of the Six Nations. The appointment was given another doctor, Dr. Digby, who maintained a private practice in Brantford, for some £50 more in salary than the former physician requested.

The desirability of immunization against smallpox during the early 1840's can also be established to some extent. "Dr. Digby in submitting his bill for treating Indians for smallpox in 1842 indicated Indians had approached him for vaccination on hearing [of] smallpox in Brantford. He had refused to act until given authorization in this case, as [in] 1836. He offered [a] certificate signed by 10 chiefs, Jan. 12, 1843 that they had agreed to pay Digby $1 per head for vaccination" (Voget, pers. comm., May 1966). It would appear that during this period Western medicine was turned to largely as a last resort when traditional methods were perceived to be unsuccessful, or in extreme cases such as the threat of a smallpox epidemic. The request for medicines late in the symptom development of a disease would seem to indicate this second-choice role of Western medicine, despite, perhaps, the Chiefs' requests for a resident physician. Other factors, however, such as differing perceptions of symptoms, dissimilar definitions of critical points in the development of an illness, differing categories of what is healthy and unhealthy, and the categorizing of diseases into Indian and white regarding treatment, as well as whatever procedures were necessary to "apply for Prescriptions," and the perceived efficacy of these medicines should be considered in an attempt to understand this pattern of behaviour.

Furthermore, it is not unreasonable to speculate that the traditional Iroquois methods of coping with illness (including herbal remedies adopted from white settlers) were the first turned to when sickness occurred. These were the methods that had served the people in the past, and the migration alone would not have been sufficient to inhibit the use of these remedies, or to result in a loss of faith in their efficacy. Since the flora of Ontario is comparable to that of the Iroquois' original home in New York State, herbal practices probably required minimal adjustment to the new setting. It would simply be necessary to locate these familiar plants in the new locale.

Another factor to consider with respect to the continuance of traditional Iroquois medicine is the effect of Christianity. The fact that the Christian Iroquois in one Grand River settlement in 1798 did not actively participate in a Longhouse feast intended to ward off sickness, among other things, has already been noted. Adherence to Christianity, at least ideally, might eliminate recourse to medicine societies and other ceremonies connected with curing in the Longhouse, such as the forming of ritual friendships and the holding of curative feasts. The effects of Christianity upon the more pragmatic aspect of Iroquois medicine—herbal remedies—would appear to have been less immediate, as the use of plants believed to have medicinal properties, always less extensive than among the Longhouse Iroquois, was retained among Christian families until the early 1900's. The practice was probably retained because although certain beliefs and rituals accompanied the collection and administration of herbs by a specialist, these did not necessarily apply for the ordinary individual. Thus an individual could continue relying on or simply sporadically using herbs without necessarily having an ideological commitment to the Longhouse faith.

Over the years the continued use of plants by the Christian Iroquois for treating illnesses has involved a shift in the believed source of curative power, from the spirits summoned through the offering of tobacco to the plant to the natural substances in the plant itself. Hence, what was once originally a supernatural source of curative power has been reinterpreted through the years by the Christian Iroquois as a natural source.

In all probability, traditional Iroquois methods of prevention and cure were dominant during the period between 1784 and 1850. After 1850 the Christian Iroquois began to rely more on the medical technology of the contact culture.

The period from 1850 to 1900

The midpoint of the nineteenth century marked the beginning of the permanent establishment of physicians whose sole responsibility was the medical care of the Six Nations. Although appointed through the Indian Department, not always actually by the Department, the physicians received monthly salaries from the Six Nations band funds, as well as a prescribed sum for purchasing medicines. From the Six Nations point of view these physicians were their "own" doctors, and from the Council's view the physicians were primarily responsible to the Six Nations for their actions. The fact that the doctors were financially supported from their own band funds, independent of governmental assistance, was a source of pride to the Six Nations and a symbol of their desired autonomy in managing their own affairs.

In 1853 Dr. R.H. Dee was appointed Medical Officer of Health for the reserve and was responsible for patients in the "central beat," running north and south through the reserve. Unlike his contemporaries, Dr. Wicker and Dr. Digby, who had the eastern and western "beats," Dee became a resident physician and attended the Six Nations people for thirty-six years until his retirement in 1889, when he was pensioned by the Council in appreciation of his many years of service. Between 1889 and 1900 there were two succeeding senior physicians, Dr. Langrill and Dr. L. Secord, and each was aided in his duties at most times by an assistant physician who was similarly paid from band funds. It was the senior physician, however, who carried out the bulk of office and house calls.

At that time patients were usually treated at the doctor's office, even before the Council built an official doctor's residence in 1885. An earlier plan (similar to the tripartite division in the 1850's) to have the reserve attended by two physicians, each responsible for approximately half the area delineated by a north-south boundary through the middle of the reserve and each having his own residence in the middle of his "beat," was found unacceptable by the Council despite the fact that they had originally proposed the idea. The rejection of this plan to increase physicians' services stemmed partly from the issue of cost but more significantly from the Indian Agent's hasty request for tenders to erect the buildings without first having obtained consent from the Council (Minutes, January 20, 1885, p. 232). The single residence built in Ohsweken was intended to establish the physician as a permanent feature of reserve life; with one exception, the doctors subsequently holding the position of Medical Officer complied with the Council's wishes.

Although most patients were treated in the physician's office, many house calls were made, thereby exposing the Six Nations to certain procedures the doctor used in handling disease and injury and giving the doctor, in turn, an opportunity to observe the social and physical environment of the families on the reserve. The quarterly reports prepared for the Council by the senior physician in the 1880's indicate the number of patients treated in home and office. In 1883, for example, before an official residence was built, a mission house served as the doctor's office, and during the months of October, November, and December Dr. Dee treated 786 patients in this office, and 395 in their homes. During the same months his assistant, Dr. McKinnon, treated 179 at the office and 125 in their homes, totalling 965 office cases and 520 house calls. These figures are comparable to those of the winter (January, February, March) of 1887, when 930 office cases and 541 house calls were handled. The inconsistency of these physicians' reports and the irregular way they were recorded in the Council Minutes renders it impossible to discern seasonal variation in frequency of total cases handled, but the data available indicate that more calls of both types were made in the fall, winter, and spring months than in the summer. In the only spring reported, 400 more calls were handled than in any other time of year.

Although the physicians' reports to the Council do not indicate the specific types or frequencies of illnesses and injuries treated, information of a very general nature is available in letters from Dr. Dee and Dr. Secord sent in 1898 to David Boyle, Curator of the Royal Ontario Museum, at the latter's request, which were subsequently published. "The character of disease affecting the Indian," Dr. Secord then stated, "is in no way different from what would be experienced among a similarly situated white population under similar conditions; but we have at times been particularly struck with a wonderful recuperative power shown in some cases" (Boyle 1898: 192).

His statement particularly applied to the prevalence of malaria among the Six Nations and other communities along the Grand River, where it had existed, as previously noted, even before 1850. This disease "in its many and varied forms" diminished in occurrence only toward the end of the 1800's when the marshlands created by damming the river were finally drained (Dee *in* Boyle 1898:

189). Also prevalent were pneumonia and tuberculosis, particularly of the lungs and the cervical lymph nodes ("scrofula"), "which claim[ed] a great number of victims" (Secord *in* Boyle 1898: 192). In the 1890's the number of typhoid fever cases began to increase steadily as did all the above-mentioned illnesses except malaria. The incidence of measles, whooping cough, and scarlet fever, Dr. Dee claimed, was "about the same as among white folk" (Boyle 1898: 189). A smallpox outbreak apparently occurred only once during Dr. Dee's residence, and then only to a minor extent. As Dr. Secord makes no mention of this disease in his 1898 letter, one may assume that it was rare or nonexistent at that time.

Although the types of diseases suffered by the Six Nations were not dissimilar to those experienced by non-Indians in comparable circumstances, their mortality rate when compared with that of the province as a whole was much higher. In 1898, for example, it was three times as great as the provincial rate; there were thirty deaths annually per thousand population on the reserve as against ten deaths annually per thousand population of Ontario (Secord *in* Boyle 1898: 191). Despite this high mortality rate, the birth rate was often higher, resulting in a gradual increase in the reserve population from 2,600 in 1868 to 4,000 in 1898.

Efforts to introduce measures to prevent or more effectively treat illness were · undoubtedly made throughout the mid-1800's, but evidence as to the nature of these attempts and the Six Nations response is meagre until after 1890. That people of the Longhouse were in the 1890's still relying primarily on the traditional Iroquois methods of treating disease and injuries is seen in the following statement by Dr. Secord:

> Among the Pagans it is quite common to find a patient's bed surrounded by curtains to keep him or her from being defiled by contact with the outer world. The sick person may be kept for days in this seclusion and fed on *white* chickens and *white* beans, this diet being symbolical of purity. The Indian medicine women administer some medicine, usually herbs or roots, in the efficacy of which they themselves have no faith, but put all their trust in superstitious ceremonies, and invocations to the Great Spirit. A physician is only called after this method of treatment has proved to be of no avail, or after some intelligent advisor has succeeded in getting the patient's consent to have the doctor. This condition of affairs is, however, fast improving, and I am of the opinion it will not be many years before the Pagans will all recognize the efficacy of modern medical treatment [italics are Dr. Secord's] (Boyle 1898: 191, 192).

Efforts to introduce preventive measures, particularly to reduce the mounting number of typhoid fever cases, appear to have been accepted by some Six Nations, but the effects were often the antithesis of the desired results. Dr. Secord wrote:

> In connection with the spread of this disease it is interesting to notice how that which is intended to be useful will sometimes be utterly perverted.
>
> It has been known for years that parts of some of the streams flowing through the Reserve have been polluted with typhoid germs, and the digging of wells has been advocated for the purpose of preventing the Indian from using surface and creek water. In many cases wells have been dug, but there are wells and wells, and while a good one serves the purpose intended many of those which have been sunk are but a few feet deep and placed in such situations as to receive the surface water for rods around, this being to the Indian a great advantage, inasmuch as the well is not so likely to go dry, but, unfortunately, it has probably increased very materially the number of cases of typhoid fever which have affected the people (Boyle 1898: 192-193).

Concern over the pollution of another immediate source of water, the Grand River, was manifested on several occasions in the Council proceedings, but measures to prevent this pollution, which came largely from factory waste and sewage from towns above the reserve, were ineffective.

On a more positive note, the idea of immunization against smallpox had been introduced and by 1890 had been accepted as an effective preventive measure. About the occurrence and prevention of smallpox Dr. Dee wrote:

> Small-pox came among the Pagans once, but the number of cases was not very great and the deaths were very few, because the people were not only willing but anxious to be vaccinated, and vaccination never failed to protect (Boyle 1898: 189).

By the 1880's, furthermore, hospitalization for treatment under certain circumstances was a familiar procedure to the Six Nations. In fact, the very day the first hospital opened in Brantford in 1885 the Council voted to send a patient there, and it continued this practice for cases of a more serious nature (i.e., cancer, typhoid) as recommended by the resident physicians. Prior to the building of this Brantford hospital, referral cases were sent to the hospital and asylum in Hamilton as necessary. Later the few epileptic persons without families to assume responsibility for their care were sent to a special institution in Woodstock, not far from the reserve. Finally, when sanitorium care was recommended to tubercular patients, and they were willing to comply, they were usually sent to the Muskoka Sanitorium in Gravenhurst, a considerable distance from the reserve.

Although the earlier part of this 1850 to 1900 period witnessed the introduction of new medical ideas and procedures, it was during the last decade of the nineteenth century that pressures to expand treatment facilities on the reserve itself were felt most intensely by both the Department of Indian Affairs and the Six Nations band Council. The pressures to extend the scope of Western medicine locally came originally not from the central Indian administration in Ottawa, but from one Medical Officer for the reserve, Dr. Secord.

It was Dr. Secord's conviction, for instance, that the high incidence of tuberculosis could be explained "without falling back upon the theory that the Indian is constitutionally predisposed to tubercular disease," and that this explanation lay in "understanding the conditions under which these people exist" (Boyle 1898: 192). His deep concern about the high mortality rate of the Six Nations stemmed from his belief that much of the illness and fatality was needless since the environmental factors could be altered by concerted efforts on the part of the Indian Department and the Six Nations Council, the bodies with power and funds to establish and support a health program.

In 1897 Dr. Secord recommended to both the Department of Indian Affairs and the band Council the building of a small hospital on the reserve and the establishment of a local Board of Health patterned on those which he believed had proved so successful within the province under the Public Health Act (Boyle 1898: 193). Although his initial attempts to convince both these bodies of the necessity of such measures were, in his words, "without avail," a Board of Health was eventually organized some three years later during his time as Medical Officer. It was not until a few years after Dr. Secord left his position that a tent hospital was established.

The proposal of a reserve hospital was first brought before the Six Nations Council by Dr. Secord in April of 1897. The Chiefs then resolved that the idea be put before the Indian Department for its consideration. After the issue lay dormant for a year, the physician again put forth the recommendation, and the Chiefs' response was to grant him permission to accompany a delegation of representatives from the reserve to Ottawa "at his own expense" to carry the matter once more to the Department. In October of 1898, apparently with little governmental support, Dr. Secord presented to the Chiefs a "scheme" for a hospital in Ohsweken, whereupon they postponed their decision until the following month when they "failed to decide to build a hospital on the reserve now" (Minutes, November 1, 1898, p. 167).

Opinions regarding the building of a hospital are not recorded in the Council Minutes. However, the evidence, particularly of the complex administrative relationship between the Six Nations Council, the resident physician, and the Indian Department, indicates that non-medical factors were as instrumental as purely medical factors in both the original resistance to and the later acceptance of the proposal.

Of primary importance is the fact that the idea for such a hospital originated at a low administrative level of the Indian Department (i.e., the physician) and, furthermore, at a time when hospitals were just beginning to be built in smaller urban centres such as Brantford. The Department's subsequent lack of endorsement of Dr. Secord's suggestions was undoubtedly a main factor in the failure of the proposal even to be effectively introduced as a measure worth consideration.

Moreover, although Dr. Secord claimed that the Six Nations were a "wealthy community" because of the $800,000 in capital band funds (Boyle 1898: 194), both the Council and the Department were most reluctant to deplete these funds. The Council's reluctance arose not only from their intense desire to manage autonomously the affairs of the reserve, but also from the desire to prevent the recurrence of unsanctioned withdrawal of funds as had occurred with the Grand River Navigation Company in the 1840's (Noon 1949: 62). The Six Nations had held more stock in this company than any other investors, and when bankruptcy was declared because of the failure of the scheme to render river navigation less costly than a competing railroad, the Six Nations lost the large sum illegally invested on their behalf. But despite the desired autonomy of management by the Council, the Department did in effect hold the purse strings, and for such an undertaking as the hospital, governmental sanction would have had to be given.

Furthermore, the relationship between the Council and Dr. Secord at that time was not one that would provide a favourable atmosphere for the Chiefs' acceptance of the physician's suggestions. The Council was dissatisfied with the way physicians were employed to attend the reserve. Although doctors were officially hired through the Civil Service Commission and the Department of Indian Affairs, they were, as stated, paid a salary from band funds and given a specified sum for purchasing medicines. Because of their financial contribution to medical services, the Six Nations Council expected a certain degree of power in return, for instance in selecting a physician, dismissing him if his activities were viewed as unsatisfactory, and calling him before the Council to explain his actions when charges of improper practice were laid against him by the residents. On more than one occasion Dr. Secord's relations with the Council had brought him into controversy because of his refusal to recognize their reputed power. He had, for instance, of his own accord dismissed his assistant physician, after which the Council promptly requested the Indian Department to reinstate the physician. Another source of annoyance to the Chiefs was Dr. Secord's persistent refusal to take up permanent residence on the reserve. Instead, he lived in Brantford, where he had built up a private practice, and commuted to the reserve a few days a week. The most critical factor in this Council-physician relationship, however, was Dr. Secord's persistent attempt to introduce change at a time when outside intervention was suspiciously viewed and frequently resisted; self-determination was the recognized ideal. It was the physician's determination that finally prompted the Chiefs to decide "that he should not inter-meddle himself with the internal affairs of the reserve" (Minutes, March 7, 1899, p. 191).

In spite of these sometimes strained relations between physician and Council, regular communication did occur. Quarterly reports, prepared by physicians from Dr. Dee's time on, presented the number of calls made and sometimes gave the general state of health of the reserve and of patients who had been referred to hospitals by the Council's permission. Furthermore, authorization for these referrals to either hospitals or specialists was required from the Council, though this permission was seldom withheld. These formal requirements for sanction not only secured the manner in which accounts of the hospital and specialists were to be paid, but acted as a channel through which knowledge of the advantages of hospitalization could be passed on to the Chiefs.

Cooperation between doctor and Council had existed for many years over the granting of relief to the sick. In 1888, for example, the Agency Superintendent wrote the following in his yearly report.

> The physician's reports of the general health of the people continue favorable, but, in his recent practice, the necessities of his patients required more than usual relief, in consequence of the crops proving a comparative failure (Canada 1889:152).

This practice was to continue for several years in spite of the occasional conflicts that did arise from time to time between the physician and the Council.

Recommendations for preventive or curative measures to be acted upon in the community reached the Council not only from the doctors indirectly through the Superintendent, who read the quarterly reports of the physicians, but from the Indian Department when such procedures as vaccination and quarantine were to be undertaken by the local doctors. The regular communication between doctor and Council through the Indian Agent and the power of the Department to hire and dismiss resident physicians were responsible for the inevitable association between medical matters and politics on the reserve. Attitudes toward the Indian Department, it seems, tended to affect the administration of medical affairs on the reserve, and this is nowhere more evident than in the following period. The political outlook of the Chiefs in the 1890's was marked by this intense desire to decide policies that would affect them and to participate in their enactment. Decisions made and subsequent courses of action taken by outsiders (i.e., the Indian Department, the physician) without the prior knowledge and agreement of the Council inevitably caused feelings of indignation that led to resistance, such as the Council's decision to establish only one physician's residence in Ohsweken.

Additional factors involved in the failure to agree on building a reserve hospital were the close proximity of hospitals in Brantford and Hamilton and satisfaction with the present referral arrangements. The fact, too, that few individuals had appeared to require hospitalization in the past may have been another reason behind the refusal. Whether the Six Nations people considered the hospital setting more satisfactory for treatment is difficult to determine from Council records. It is doubtful, however, that it was considered desirable or necessary, judging from the low attendance at the tent hospital when it was finally built, and from the Indian Agent's later recurring addresses to the Council about the merits of institutional care as opposed to family care.

Another very important factor in the opposition to the idea of a reserve hospital was the Council's position on the social ties and units that should be responsible for the care of the sick. In the Council's view, and in that of the people, this obligation lay with the immediate nuclear family, as evidenced in the Council's withholding of the annuities from band funds due the entire family unit until the hospital or specialists' accounts for one of its members were repaid the Council.

The Council's definition of the family, however, appeared in general to encompass more types of kinsmen than did the definition of the people. Aunts and uncles of ill persons without immediate families were expected to assume some responsibility for their relatives in times of illness. In most cases recorded in the Minutes, these more peripheral relatives did either render financial assistance or care for the sick person within their own homes, but Council action appeared to be necessary in prompting this care.

Beyond the nuclear family and less immediate kinsmen, the Council tended to place responsibility on friends, though certainly not to the same extent as it did on relatives. The responsibility was increased when the Council ceased reimbursing friends who transported patients to hospitals.

Only when a sick person was unable to provide for his family or when there was no immediate family to care for him did the Council feel obligated to assume responsibility. In such cases persons were sometimes paid from band funds for "taking and caring for" sick individuals. Temporary relief was given to sustain a family through a period of sickness, and no debt was considered established by this financial support if the persons involved were "poor." Permanently disabled individuals were given pensions from band funds, and those requiring artificial limbs were provided with what constituted a loan from the Council to be repaid from the family's annuities if by no other means. Hence, with the exception of providing the reserve with physicians' services, the Council placed the obligation of medical care both financially and socially on the family unit.

The Council's refusal to establish a local Board of Health resulted from many of the same factors as those responsible for the opposition to the hospital: resentment of outside intervention, the relationship between physician and Council, the absence of necessary endorsement from the Indian Department, and the Council's allocation of responsibility for coping with illness to the family unit. The issue of expenditures from band funds for such a Board was of minimal importance. It will be seen that, once the benefits of both the Board of Health and the hospital were perceived by the Council, it was the issue of Council participation that determined whether the innovation was to endure.

Throughout the period from 1850 to 1900 there was an apparent satisfaction with the type of medical services made available to the Six Nations, both in the physicians' attendance of the people and in the referral services to hospitals. Efforts to introduce both a reserve hospital and a local Board of Health were resisted, at least temporarily, as much on non-medical grounds as on purely medical ones. It appears, furthermore, that Western medicine by the end of this period had become the first system turned to by the non-conservatives when illness occurred, but the last resorted to by the Longhouse people. This variation in reliance on medical practices of the contact culture will become more obvious in the following period, when participation in instituting and maintaining Western medical procedures on the reserve is discussed.

The period from 1900 to 1927

This period was characterized by a persistent attempt on the part of the local band Council to obtain greater control over the participation in the medical services available to the Six Nations, and by a noticeable pressure on the part of the Department of Indian Affairs to expand medical facilities on the reserve, in contrast to earlier policy. In an effort to gain some degree of control, the Chiefs made both successful and unsuccessful attempts to formulate regulations defining the obligations and spheres of power of both groups and individuals (including the doctors) in a variety of situations affecting the health of the people. When situations arose in which the Council could not manipulate the administrative machinery to its satisfaction, particularly in its relationship with the Indian Department, conflict arose, which ultimately led to a program of non-cooperation with the Department. Where the two administrations sought a mutual end, the Council assumed a high degree of direct participation; for example, if circumstances required it, the Council would handle arrangements for a family disabled by illness. This type and extent of Council participation, which terminated in 1927 with the advent of hospital facilities on the reserve, has never been revived.

The Council's responsibility in medical matters was first made evident by their formulation of the Six Nations Public Health Act in 1900 (Canada 1900) in which the composition and duties of a local Board of Health were outlined, and sanitation and health regulations were formulated. The board, composed of six Chiefs, functioned from 1901 until 1924, when it was replaced in form though not in function by the Sanitary Committee of the newly elected Council.

Within a year, however, the Sanitary Committee ceased to exist.

Another responsibility was added about 1908, when the Chiefs agreed to the establishment of a tent hospital on the reserve and formed a Hospital Board to represent the Six Nations' interests in dealings with the Department of Indian Affairs about the management of the hospital. The idea of a hospital, however, was by no means as appealing to the people and the Council as to the Board of Health; the Council's refusal in 1913 to appoint a Hospital Board made obvious to the Department the Chiefs' desire to close the hospital.

This quarter century also witnessed many crises in reserve life that were not of a medical nature, but that nevertheless affected medical matters. It was a time of much political upheaval: feelings became intense first over the threatened termination of the hereditary system of local government and then over the realization of it in the establishment of an elected system in 1924. This political unrest, concentrated in the strong antipathy of some toward the Indian Department, had many repercussions on the management of medical affairs on the reserve and on the subsequent use of newly established medical facilities. Dissatisfaction and resentment toward the Indian Department's intervention in local politics were manifested in several ways: in overtly stated disagreement with the Indian Department's employment of physicians without the agreement of the Council, in sporadic complaints and then organized petitions from the people requesting the dismissal of no less than four of the five senior physicians, in the Council's final refusal to appoint a Hospital Board and allocate funds for the tent hospital, and in the longstanding opposition to the idea of a permanent hospital on the reserve.

In addition to this local political turmoil, World War I had a deep impact on the Six Nations because of the many men who entered the armed forces. The families whose members were away at war not only suffered hardship and anxiety but also, like other rural communities, were subject to additional demands for food production for the war cause. Furthermore, when the Conscription Act of 1917 was applied to the Six Nations men by the Federal Government, deep resentment arose among those who considered themselves (or the Six Nations as a whole) citizens of the Confederacy, not of Canada (Noon 1949: 60). These nationalist feelings were aroused again by the Canadian Government's ruling that all persons over the age of sixteen must register at local offices for a variety of reasons, primary among them being the location of sources of labour and food production for the war effort. Refusals to register were not uncommon, and in one instance a Six Nations man was jailed in Brantford for not carrying a registration card. Finally, the great demand for drugs during the war elevated prices, resulting in additional expense to the Council, which supplied the physician with a set amount of money for medical supplies.

In addition to these crises, there were two severe epidemics, which, while not causing a high death rate, definitely inhibited normal activities of both family and community. The first occurred in 1901, when smallpox became so prevalent that the health authorities in the surrounding townships wanted to quarantine the entire reserve (Agency File "small pox, 1901-1902"; Weaver 1969). The second occurred in 1918, when "Spanish influenza," which had assumed pandemic proportions, appeared in the fall, and then reappeared in lesser severity in late winter and early spring of 1919 (Agency Shannon File "Medical 1918-1921," April 22, 1919). During both epidemics the local physicians and the Board of Health imposed restrictions on the Six Nations people and coped with the crises largely without the assistance of outside authorities.

During this period a significant factor in the gradually deteriorating relationship between the Council and the Indian Department was the frequent replacement of physicians and the disagreement that invariably arose over employing and discharging them. Between 1900 and 1927 five doctors occupied the position of Medical Superintendent: Dr. Secord to 1904; Dr. Holmes, 1904 to 1911; Dr. Rutherford, 1911 to 1913; Dr. Davis, 1914 to 1920 and 1924 to 1950; and Dr. Greenwood, 1920 to 1923. Compared with the previous 50-year period, when only three senior physicians served the reserve, this represented considerably less stable continuity of tenure. Also, many assistant physicians came and went during this time increasing the number of new personalities in physician roles to which the Six Nations had to adjust and ultimately learn to accept with confidence.

With the exception of Dr. Walter Davis, who was raised on the reserve by an Indian family though he was not an Indian, each one of these physicians for a variety of reasons became the subject of charges and petitions by some of the Six Nations people; each was called before the Council to present his side of the case, and in each instance was dismissed from the office of Medical Superintendent by the Council. Although the discharges were not immediately sanctioned by the Department of Indian Affairs, the physicians eventually resigned of their own accord after continuing in their positions for up to one year after the dismissal. Thus, although the dismissals were not the immediate result of Council action, the Council's desired result was eventually obtained.

Dr. Secord had been discharged from his duties in 1904 at the Council's request because of his refusal to reside on the reserve; he was succeeded a little later by his assistant, Dr. Holmes, then considered by the Chiefs to be "very popular" on the reserve (Minutes, April 12, 1904, p. 602). By 1910 displeasure with Dr. Holmes's performance prompted the Council to pass the following resolution.

> The Council after hearing the Petition and charges against the Medical Supt. Doctor Holmes read decided that he be dismissed from the position of Medical Supt. of the Six Nations upon the grounds as set forth in the petition fyled [*sic*] by the warriors charging him with negligence of his duties and a lack of regard and attention in cases where he is summoned to visit patients, also upon the grounds that he refused to come before the Council when officially summoned by it to face his accusers, and answer their charges. There are also other charges which were read to the Council and have not been refuted.
>
> The Council is of the opinion that, as Doctor Holmes is paid out of the funds of the Six Nations, he should at least have been courteous enough to the Six Nations Council to have attended the meeting when summoned instead of writing an insulting letter to it in which he refused to come.
>
> The Council are alive to the fact that there must be sympathy between patient and the Doctor and as there can be none exist between the petitioners and him his efficiency and usefulness will be utterly gone in so far as they are concerned (Minutes, December 13, 1910, p. 112).

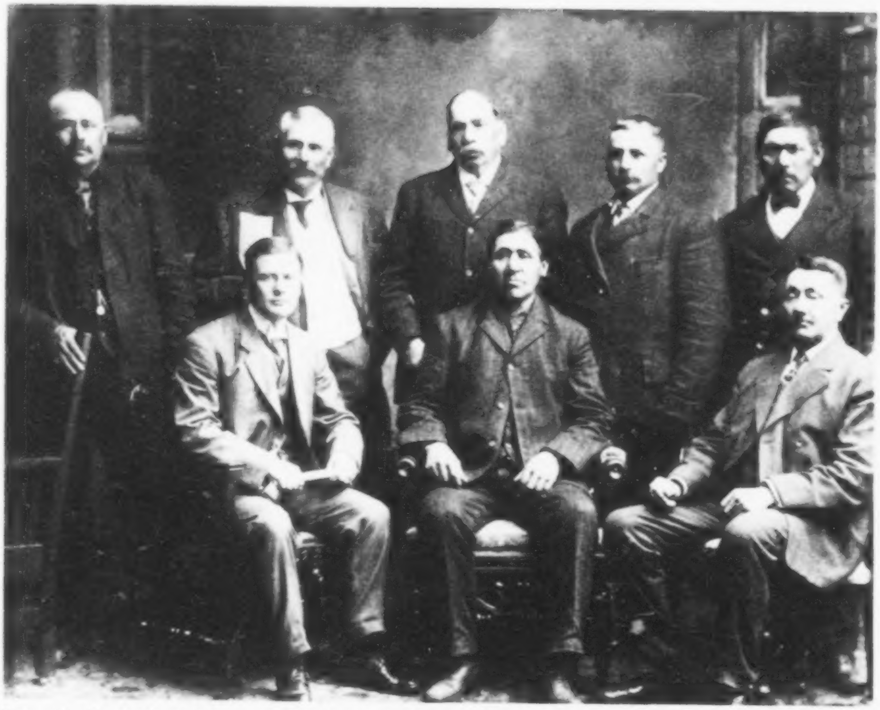

Plate IV. Dr. C. U. Holmes and Chiefs (dated between 1900 and 1910). Standing L to R: Alex Lottridge, Jacob S. Johnson, Josiah Hill, Peter M. Jamieson, George Gibson. Seated L to R: Dr. C. U. Holmes, David John, William Smith I. (Courtesy Mr. Clarence Jamieson).

Anticipating the resignation of Dr. Holmes in the summer of 1911, the Council requested from the Indian Department "the names of Doctors who may apply for the position of the Medical Superintendency of this Reserve and give them a chance to select and recommend someone who the Council may think best qualified for the position" (Minutes, June 12, 1911, p. 246). A month later, the Chiefs, expecting, not unrealistically, little authority in choosing their Medical Superintendent, passed the following resolution.

> The Council claim that the appointment of the Medical Supt. of this Reserve belongs to this Council and will therefore insist that they must have something to say in the new appointment that is going to be made now (Minutes, July 11, 1911, p. 254)

Soon after this statement of their rights was made and when the requested list of physicians was refused them, the Chiefs decided to present their claim to the Superintendent General of Indian Affairs in Ottawa through a delegation of three appointed Chiefs. There is no evidence in the Council Minutes of the actual appointment of this delegation, but a product of this characteristic freely expressed discontent was a Government instruction that the Council, in their Secretary's words, "write the contract to govern the Medical Superintendent's Office upon the Reserve" (Minutes, August 2, 1911, p. 268). This formal defining of the Medical Officers' duties had also been proposed in 1909 by the Chiefs themselves; at neither time, however, were the regulations formulated.

The Department's selection of a physician to replace Dr. Holmes not unexpectedly met with Council disapproval "because they were slighted and over ridden by the government in the appointment" of Dr. Rutherford (Minutes, March 19, 1912, p. 406). On the same day the Chiefs again attempted to relieve the Medical Officer of his duties "because of the unsympathetic feeling of the Reserve generally toward him" (p. 408).

After Dr. Rutherford was replaced the following year by Dr. Davis at the Council's recommendation, there followed six years of a quiet, highly satisfactory physician-Council relationship from the viewpoint of both the Chiefs and the people. But when the Department failed to increase Dr. Davis' salary to the level he had requested, he bought a practice in Toronto and resigned his position on the reserve. Despite a petition raised by nearly two hundred members of the reserve asking the Department to grant the increment, and the Council's approval of the raise, Dr. Davis left the reserve in 1920 (Agency Shannon File "Medical 1918-1921," April 16, 1920). He was succeeded by Dr. Greenwood, who after some three years was ineffectively discharged by the Chiefs, a year before his actual resignation. At the Council's request, the Department then rehired Dr. Davis, whose return brought, as the Secretary recorded, "satisfaction and applause" from the people gathered in Council (Minutes, December 4, 1923, p. 346).

The relationship between the Council and the Medical Officer during the period from 1900 to 1927 was the product of many factors, most of which were operative in the late nineteenth century and were simply intensified by the growing antipathy toward the Federal Government. Similarly, among these many considerations, non-medical ones were not insignificant.

The continued refusal of the Department to allow the Chiefs to select their senior physicians remained a constant source of discord between the Council and the Department and led to frequent dismissals of physicians. It was largely this frustration of a perceived political right that prompted the people to prepare petitions and the Council to accept them. When it became evident that a physician did not feel obligated or inclined to explain his actions to the Council, opposition to his remaining in office was intensified.

Communication from physician to Council, particularly in the form of quarterly reports, had ceased about 1920, leaving the Chiefs less informed about medical activities on the reserve. But requests from doctors for referral of patients to hospitals were still necessary to ensure payment of accounts, and thus some information did reach the local governing body. This sanctioning of referrals, although it limited the freedom of the physician to prescribe hospital care for the sick and was undesirable for that reason, was a compulsory procedure if good relations with surrounding hospitals were to be maintained for the benefit of the Six Nations.

The relationship between Council and Medical Officer, although deeply enmeshed in the political unrest of the day, is not entirely accountable in terms of politics. The doctor-patient relationship, admittedly varying with each patient, tended to produce certain recurring complaints from some of the Six Nations people. Some of the complaints regarding the physician's negligence of duty, for example, stemmed from the failure of messages requesting the doctor's services to reach his residence. As late as 1924, when some Indian families already had installed telephones, the physician's residence was still without such a utility. Requests for the doctor's assistance were frequently phoned to the general store in Ohsweken, and occasionally were not delivered to the doctor until the following morning (Agency Shannon File, "1918-1923," Oct. 27, 1921). This left the Indian family to cope with a medical and emotional crisis as best they could without the aid of a doctor. Although cases of this type were dismissed in Council as legitimate negligence on the part of the physician, they were not so lightly viewed by the families concerned.

When outside physicians were called in because the Medical Officer could not be reached, the issue of payment of an unauthorized account would be raised by both the Council and the Indian Department. However, many families on the fringe of the reserve regularly relied on outside physicians and paid their accounts themselves, a situation Colonel Thompson felt to be most inequitable to these families (Thompson 1924: 9).

At other times, the physician, absent from his residence attending a case, could not be contacted regarding a later request for his services. The unreliability of some of the assistant physicians (some of them were still medical students) (Agency Shannon File "Medical 1918-1921," Nov. 23, 1920 and Jan. 6, 1919; and "1918-1923," March 13, 1922) and the not infrequent vacancy of the position further inconvenienced families faced with illness, in addition to placing a greater workload on the senior physician. Some requests for the doctor to call proved in the physician's estimation unnecessary, further straining the doctor-patient relationship and affecting the possibility of future visits (Agency Shannon File "Medical 1918-1921," May 16, 1919).

Another source of discontent was the problem that arose when minor surgery was to be performed in a home that the physician considered unhygienic (Agency Shannon File "1918-1923," May 8, 1922). In some instances the physician removed the patient to a neighbour's house or to his office in order to operate where conditions were more favourable. Dr. Greenwood incurred particular disfavour from a small portion of the people when he attempted to stringently enforce treatment for venereal disease. Dr. Greenwood, one informant stated, "made it almost compulsory for them to get treatment. He'd get the police [the local constable] and that made him unpopular to a certain class of people."

Some of the complaints or feelings of reservation about the physicians stemmed from either a lack of understanding of the reasons behind certain types of treatment or dislike of the treatment itself. The treatment for syphilis, for example, was a long and unpleasant experience for the patient, which was undoubtedly one factor in the reluctance to submit to therapy. On one occasion the doctor "almost lost" two female patients being treated for syphilis because of his inability to procure the distilled water required (Agency Shannon File "Medical 1918-1921," July 16, 1921). One informant told of how her mother "had never liked Dr. . . . because he wouldn't give my mother anaesthetic when I was born and she really suffered. She had a cold at the time." Food deprivation, then prescribed in the treatment of typhoid fever, similarly drew disagreement, although it did not necessarily result in the discarding of the prescribed regimen. As one informant phrased it, "They used to starve you to death, you were nothing but skin and bone when they finished with you." Another informant described this food deprivation as "awful" when applied to children, a not unexpected reaction when one considers the indulgent attitude toward child training, particularly during illness.

Attitudes toward specific treatments tended to encompass the prescribing physician; if the treatment was considered worse than the illness itself, the doctor's prestige suffered as well. The more stringently recommendations were enforced or promoted (as in the case of Dr. Greenwood), the greater was the negative effect on the doctor-patient relationship.

Throughout this period from 1900 to 1927 there were legitimate complaints against the physicians. One, for example, involved the Chiefs' questioning the repeated absences of Dr. Holmes from the reserve.

> The Council decided to lay a complaint against Doctor Holmes Medical Supt. to the Department of Indian Affairs for his neglect of duty. Since last Spring he was away to Military School about two weeks, Camp at Niagara two weeks, attending Courts at Toronto for days at the time, attending races, and frequently away to Muskoka shooting deer. The Council therefore ask the Department of Indian Affairs as to whether they were so generous toward Doctor Holmes as to give him a leave of absence every few weeks. On the night of 31st ult. in which the shooting occurence [sic] took place at the longhouse, the men took the injured young man to the Hospital only to find out that the Medical Supt. Holmes was away to Muskoka, and the man was bleeding copiously, and the assistant Doctor was called away during the night attending a case of confinement some six or seven miles away from Ohsweken, and the father of the injured young man was obliged to call in Doctor Maw of Caledonia, and afterwards the patient was removed to the Brantford Hospital where he is now under the care of Dr. Secord (Minutes, November 2, 1909, p. 355).

This complaint was upheld by the Agency Superintendent, who later notified Holmes that his absences from the reserve were without Agency sanction, and henceforth that approval must be obtained prior to taking temporary leave. It should be noted, however, that in none of the cases in which the Council dismissed its physicians did the Superintendents express agreement with such measures in their correspondence with the Indian Department.

Despite the repeated charges against the physicians, a factor of signal importance is that there is very little evidence in the Agency records, the Council Minutes, or in data gathered from informants indicating that more than a small minority of the Six Nations was dissatisfied with these physicians' performances. Informants agree that with the possible exception of one physician, these men "knew their business." Furthermore, many older people were unaware of the conflict between the Council and the physicians.

The complaints and petitions originated not only from the Chiefs, who were angered at their failure to control the employment, discharge, and conduct of their doctors, but also, during the latter part of this period, from political agitators promoting the retention and later the reinstatement of the hereditary Council (Agency Shannon File "Medical Supt. Jan. 1924-Dec. 1928"; July 7, 1924). With strong anti-government feelings and organized action they persistently attempted to defend the rights of the Confederacy, which, not unrealistically, they deeply feared to be in jeopardy. The right to select their own physician was just one of the many rights they felt were denied them (Agency Shannon File "Col. Morgan and Dr. Scott, 1924-25," May 9, 1924).

Many of the diseases suffered by the Six Nations during this period were coped with by quarantining procedures to prevent further infections. Preventive measures such as effective vaccines (except for the long-available smallpox vaccine) had yet to be developed. Moreover, the diseases existing at this time differed little from those that had prevailed in the latter part of the nineteenth century, except that smallpox and diphtheria were more prevalent.

During the spring and early summer of 1901 an epidemic of smallpox broke out on the reserve, causing the health officials in the adjacent townships considerable apprehension (Agency File, Small pox, 1901-1902). Fear of smallpox spreading into adjacent areas led them to pressure both the Indian Agent and the Medical Officer to quarantine the entire reserve. The Board of Health of Hamilton prohibited two railway companies from carrying Indian passengers until the Indian Agent was able to obtain the removal of the restrictions by quarantining certain sections of the reserve.

Council action to alleviate the crisis was immediately effected. Guards were employed and placed at strategic locations around the six quarantined blocks (most of which were in the "down below" area) to ensure that no one violated the quarantine. In addition, the local Six Nations constable patrolled the roads by horse and buggy to give even further assurance against violations. Food supplies and other necessities were brought to the families in the quarantined areas and left at the road to be picked up by someone in the household. A house near Number 6 school was "turned into a pest house" for the sick, and additional tents were brought in and set up in the other blocks for the same purpose. Dr. Secord's son, Dr. E. Secord, was brought to the reserve from Montreal for a period of four months to take charge of the quarantined areas, since this was preferable to having the physicians travel among both those contaminated and those who were not.

The Council granted funds required to support the quarantining measures (Minutes, June 5, 1901 (?), p. 383-384). But one month later, displeasure among the Chiefs arose at "the great and continuous expenditure of quarantine, when it is almost certain that it is only chicken pox and not smallpox. The Patients are allowed to eat solid food such as pork and pickles, etc which if it were small pox would certainly prove fatal to all of them" (Minutes, July 2, 1901, p. 388). This displeasure led them to vote the sum of $100 to bring "competent" medical officers to the reserve to diagnose the disease properly. The stigma attached to the Six Nations at that time, because of the outbreak of the epidemic, the expenditure of funds, and the lack of confidence in the physician's diagnostic ability, motivated this Council decision. The medical officers, brought to the reserve, verified that the disease then rampant was indeed smallpox. Although believed to have terminated in September of 1901, the epidemic returned in milder form in the fall and the winter of 1902. A total of 50 persons had suffered from the disease, but none died and only a very few were left permanently pock-marked.

For the remainder of this period, however, the threat of smallpox was continuous. In 1907 and again in 1919 the Indian Agent appealed to the Council to deter Indians from going into Brantford because of the prevalence there of the disease. Immunization was repeatedly urged by the Indian Department, but although many had been and were being vaccinated during this time, there was no systematic infant or child immunization program. Isolated cases of smallpox appeared throughout this period, and it became more frequent in 1920 and 1921, but it never gained epidemic proportions. One informant recalls a quarantine being imposed on her family when her father suffered from the disease. The Council hired two men to enforce the quarantine for a six weeks' period; one was a "day guard" and one a "night guard." These men were ideally to remain outside the house at all times, but "one came in every afternoon for a cup of tea." They performed the necessary "chores," chopped wood, milked and fed the cows, and ran errands. At the beginning of their isolation, all the food in the house had been "sealed up" by the doctor, so the informant said, because of "germs in it," and they were given new supplies at regular intervals. Her father was confined to bed for about three weeks; after he was feeling "good," he was allowed up and one day "ran away," taking a walk up along a creek bed out behind their property beyond the quarantined limits. The guard, she said, did not inform on her father because his pay would be "docked" by the Council.

The second epidemic of this quarter century, the pandemic Spanish influenza, took place between September and November of 1918 and claimed forty-nine lives (Agency Shannon File "1918-1923," Dec. 2, 1918). During its course, many schools were closed, and until the disease abated public meetings were prohibited by a joint order of the Medical Officer and the Board of Health. The following spring the flu again occurred, but in a less severe form, and resulted in seven deaths. As before, a few schools were closed for a short period, but no restrictions were placed by the Board of Health on public meetings.

On the reserve, diseases of endemic proportions were tuberculosis, diphtheria, typhoid fever, and pneumonia. Though typhoid fever had increased steadily in Dr. Secord's time, it was somewhat less prevalent than diphtheria. Sporadic outbreaks of the latter disease, particularly in 1918 and 1920, were controlled by quarantining through the Board of Health and the closing of a few schools. Regarding the effectiveness of such methods and adherence to doctor's advised regimen, one anonymous physician claimed:

> It is difficult to get them to carry out prescribed treatment, and to observe quarantine. For instance, last fall [1922] I treated six cases of diphtheria, and in my opinion there need only have been two, but for visiting back and forth. I think if some example were made for breach of quarantine and other health laws it would have a good effect (Thompson 1924: 8).

In one particular instance efforts to have the health laws enforced proved unrewarding to Dr. Greenwood. In regard to syphilis Thompson relates Dr. Greenwood's comments:

> Dr. Greenwood, until very recently the resident Government physician upon the reserve pointed out that venereal disease, especially syphilis, was far more prevalent there than in white communities. He ascribed this, in large part, to the unwillingness of the Indians to undergo the long course of treatment necessary to effect a cure, to uncleanliness, and to gross disregard of all means to prevent contagion. He stated that he had brought about some prosecutions under various health laws in this connection, but that the magistrates trying the cases seemed quite oblivious to the seriousness of the matter, dismissing the accused with penalties so light as to destroy what should have been the benefits of the proceedings (1924: 8).

The bylaws regarding health on the reserve, as far as could be determined from both Council Minutes and Agency records, were never enforced to the extent of imposing the stipulated penalties or confinements in jail set down for certain offences.

Tuberculosis continued to be prevalent, producing a death rate higher than that of the surrounding communities. The fact that not a few families "were almost wiped out" by this disease fostered the belief that consumption tended "to run in families," which succumbed to a vaguely defined combination of contagion and heredity. The high incidence of the disease aroused the concern of the Indian Department to the extent that they recommended to the Council that a hospital be built on the reserve where tubercular patients could be cared for near home without endangering the lives of other members of the family. In 1908, for example, Dr. Holmes, in attempting to demonstrate the need for such a hospital, informed the Chiefs that fifty persons were then suffering from the disease, and two hundred more "were exposed to its ravages and were in serious danger" (Minutes, May 11, 1908, p. 20). Recommendations from physicians for the hospitalization of consumption victims, however, did not frequently meet with approval of Indian families, because this usually involved long periods of estrangement from the family at a time when their emotional support was expected and desired. Furthermore, the fact that in the earlier years sanitoriums were at a considerable distance from the reserve made visiting extremely difficult. Another very significant factor in this reluctance was the idea held that tuberculosis was inevitably fatal, a belief consistently reinforced by the high death rate of its victims. As one informant phrased it: "it was a foregone conclusion that you were going to die if you contracted TB in those days. No cure for it, no escape." The empirical validation of this belief, which placed the idea of estrangement from the family in the realm of the unnecessary and the undesirable, accounts in part for the reluctance to send individuals even to the tent hospital on the reserve.

Other diseases existing at this time, but by no means so prevalent as TB were rheumatism, neuralgia (Thompson 1924: 7), and the communicable diseases such as measles, scarlet fever, and whooping cough. The individuals having these contagious diseases were usually the subject of quarantine measures, although they were imposed with less stringency than for smallpox. Placards bearing the name of the disease present in the household were given to the families to be placed in a window or doorframe to warn any visitors. Broadcasting illness in this way was unpopular with some people, but the cards were usually used as intended by the Board of Health. One informant laughingly recalled the use of the cards to keep unwanted visitors away from the house.

Efforts to establish preventive measures were made at several levels of administration. In one instance, a branch of the Women's Institute on the reserve requested the medical inspection of all school children. The quarantining of infectious cases, imposed by both Medical Officer and Board of Health, was one type of control and containment of disease; immunization against smallpox was another but was less regularly applied. In 1924, a year after the request from the Women's Institute, Dr. Davis undertook the first organized medical inspection of school children in five schools near the end of the final term. Of the 150 children examined, only eleven had been vaccinated against smallpox. Furthermore, the dental inspection revealed "many bad teeth" among children in all the schools visited. The following September these children were to be vaccinated, and the remainder of the schools visited, but no mention was then made of the "bad teeth" (Agency Shannon File "Medical Supt. Jan. 1924-Dec. 1928," July 15, 1924). As there was no provision for dental care in the medical services available to Indians at that time the procuring and payment of dental services were left entirely to the Indian family.

In addition to the many preventive measures undertaken by the Board of Health and the two public health lectures given by the Medical Officers in the Council House, attempts were made at different administrative levels to procure the services of a public health nurse. The first was made in 1920 by a Dr. Pentland, acting Medical Officer until the position was filled by Dr. Greenwood. In a letter dated June 9, 1920 to the Deputy Superintendent of Indian Affairs, Dr. Pentland suggested the "employing of a nurse to instruct the Indian people" on matters of hygiene. As well as an educational role for such a nurse, he made another proposal.

> Another way in which a nurse could be very useful, a case in point, I was called to a case of confinement Saturday at midnight an hour afterwards another case turned up and no doctor within 10 miles, and they had to get on as best they could. I saw the woman yesterday and she was suffering in consequence. If a nurse was available it would have been a good thing. The case I went to proved a very bad one. Mother and child was in danger. I could not trust an Indian to give chloroform, and I had to call in Dr. Quane [Quinn?] (Agency Shannon File., "Medical 1918-1921").

The Indian Agent agreed with Pentland's proposal, and although he recommended such a nurse to his superior, no subsequent action was taken.

Three years later the succeeding Indian Agent forwarded a similar suggestion to Ottawa recommending a nurse who was a certified "Midwife and Children's Welfare Nurse." He wrote as follows:

> In view, however, of the number and amount of accounts which I have received in this office from local doctors for confinements on the reserve, it would seem that a considerable saving might be achieved by her presence, holding as she does C.M.B. certificate which qualifies her to conduct confinements in the absence of Medical man [sic]. There are in most sections of the reserve one or two Indian women who act as midwives on occasion. If these women were properly organised and instructed by Miss Dale there would be a capable woman within reach in all cases of emergency, and this besides reducing the risk of loss of maternal and infant life, would greatly lighten the Medical Officer's work (Agency Shannon File, "1918-1923," Oct. 22, 1923).

The Deputy Superintendent replied as follows:

> while we appreciate that the appointment of Miss Dale might have very beneficial results to the Indians of the Six Nations agency, it will not be possible for us to give consideration to her appointment. A position of this kind is not provided for in the establishment of the Department, no funds have been provided by Parliament for payment of the salary, and, at the present time, it is not possible for us to increase the expenditures at this Agency (Agency Shannon File, "1918-1923," Oct. 26, 1923).

About the time the second Indian Agent requested the appointment of a public health nurse, Colonel A. Thompson was compiling his report of "the affairs of the Six Nations Indians."

> I recommend that a properly qualified nurse be appointed with residence at Ohsweken, to assist the resident physician there, one of whose duties it shall be to visit the schools at brief intervals, supervising sanitary conditions, and examining into the health of the children in attendance. In my opinion this is a matter absolutely vital to improved health conditions on the Six Nations Reserve (1924: 8).

As in the case of the initially attempted innovations of the Board of Health and the tent hospital (which had originated at a low level in the Indian administration) although its value was not denied, this request was not acted upon by the Indian Department for a variety of reasons, among which financial considerations were not insignificant. This type of nurse, essentially a public health nurse, did not become an active part of the medical staff of the reserve until the 1950's when the Department of National Health and Welfare assumed responsibility for managing Indian medical services.

The Board of Health, 1901-1924

Indian Affairs support for proposed innovations originating from a local level of administration was necessary for the establishment on the reserve of new forms of medical services such as the Board of Health, the hospital, and a public health nurse. But this federal governmental support, clearly evident from the previous discussion, was by no means sufficient reason for Six Nations acceptance of new ideas, indeed a good basis for their rejection. The major issue in the Council-Department relationship, however, was the Chiefs' desire to "have a say" and participate in the management of the reserve. The opportunity of at least partly achieving this dominant political goal in one area of local administration was primarily responsible for their acceptance of the idea of a Board of Health. Another significant consideration was the evident minimal cost of maintaining such a Board and its operations.

The idea of a Board of Health was reintroduced to the Council in November of 1899 by Dr. Secord. The Chiefs' decision postponed the debate of the issue until the first Council session of the new year, when arrangements were made to "consider the question" in March of 1900. One informant recalled that meeting:

> There was a Dr. Manchester from Toronto [position not remembered]. Major Gordon Smith was Superintendent at the time. I don't know how it [the meeting] was organized. They made arrangements to have a time at a Council meeting [for him] to address them at Council. They were horse and buggy days. I remember the meeting. There was opposition of course, to the organization of a Board of Health on the same old grounds [he later clarified this by saying "encroaching on Indian rights"]. They postponed it a week or so to give it full consideration. They approved of it. I was rather surprised they did. They immediately started to organize a Board of Health. They appointed a committee of Chiefs to get in touch with the surrounding municipalities to get pamphlets or circulars to get their local organization. The committee got to work met several times and with all the information they could gather, and from that compiled these regulations. Up to that time they had no laws governing that [mentioned that one could leave the carcass of a dead animal "to blow to the winds" on the ground without burying it]. The same with wells—there were epidemics of typhoid, whole families would be stricken by typhoid because of the sanitary conditions. They started to give loans for building wells from band funds.

Within a month, the committee of four Chiefs had drawn up the bylaws governing the local Board of Health; these were printed in the following summer under the title of the Six Nations' Public Health Act (Canada 1900). The regulations stipulated that there were to be six Chiefs appointed to the Board of Health, including a representative from each nation, a secretary for the Board, a chairman, and Sanitary Inspectors, the latter positions being optional. Only the secretary was to receive a "salary allowance" of an amount determined by the Council. Board appointments were to be made at the first general Council meeting of each year, and after the first series of retirements (two Chiefs were to hold office for three years, two for two years, and two for one year), the positions were to be held for three years. An annual report of Board operations and of "the sanitary condition of the band" was to be prepared by the secretary, and transferred "through the proper channel" (i.e., the Council) to the Indian Department. Funds to support the Board's program could be voted by the Council, but they were under no obligation to do so.

The many duties of the Board outlined in the bylaws fell into several categories.

(1) The inspection of ice and foodstuffs sold on the reserve.
(2) The investigation of all complaints regarding health hazards on the reserve.
(3) The prevention of pollution of water sources on the reserve such as wells, ponds, and streams.
(4) The standardization of the depth of graves at no less than five feet, and the ensuring that burials were confined to the recognized graveyards on the reserve.
(5) The inspection of houses and other buildings from time to time or when cause arose regarding sanitary conditions, and the ordering and enforcing of the removal of these undesirable conditions.
(6) The communication of knowledge of communicable and infectious diseases to the Medical Superintendent.
(7) The disinfection and cleansing of houses and property in houses

in which smallpox, diphtheria, scarlet fever, and cholera have been found to exist.

(8) The prevention of the spread of contagious diseases, either by isolation, notification by signs placed in doors of houses, hospitalization of sick individuals, or by prohibition of public meetings.

(9) The meeting with the public twice a year to explain the duties of the Board and answer any questions.

To a lesser degree, the regulations defined the responsibilities of the Six Nations people in regard to health and sanitation. Individuals, particularly teachers, aware of the existence of smallpox, diphtheria, scarlet fever, cholera or typhoid fever, were to report this knowledge to either the Medical Superintendent or the Board of Health, and to see that children with these diseases be kept home from school until a certificate from the Medical Superintendent was obtained. Adults with these illnesses were to remain within their own homes until the Medical Officer had declared them to be completely recovered. The Medical Officer was required to give two public lectures a year on topics of significance to the general health of the people.

In addition to outlining the obligations of the Board, the bylaws gave the Chiefs on the Board and the Medical Officer the power to carry out their duties: the right of entry into houses when conditions appeared to warrant inspection, and the right to enact the procedures necessary to remove the undesirable conditions. Specific penalties were stipulated in the Act for certain offences, bearing on the judgment of a Justice of the Peace, Magistrate, or Indian Agent. If "poverty or other sufficient cause" rendered persons unable to carry out such recommendations, any resultant cost of such measures was either to be borne by the band or to be taken from the family's annuities. Certificates could be obtained by those unable to carry out the Board's recommendations, which exempted them for a six-months' period from "all proceedings against such persons" (Six Nations' Public Health Act 1900: 8).

Not until a year after the passing of these bylaws, however, did the Council appoint Chiefs to form the Board of Health. Reasons for this delay are not explicit in the Council Minutes, but brief mention was made of a "petition against the Board of Health" received by the Chiefs (Minutes, February 6, 1901, p. 356). Unfortunately, as with many references to petitions, there is no mention of the nature of the opposition, the number of people involved, and the groups that they may have represented. Despite this organized opposition, the Chiefs resolved that "the bylaws shall be put in force, as was intended in the first place" (Minutes, February 6, 1901, p. 356). Some further evidence of the probable source of initial resistance comes from Council Minutes after the Board's formation.

> The Council decided to appoint Chief George W. Hill to take the vacancy in the Board of Health caused by the resignation of Chief George Gibson. Chief Hill will represent the Senecas in the Board as *all the Seneca Chiefs seem to refuse to be appointed to the said Board of Health* [italics mine] (Minutes, June 7, 1901, p. 384).

Although at this time almost all the Seneca Chiefs were Longhouse adherents, most of the Chiefs on the Board were Christians. The dissension between the Christian and Longhouse factions in the Council may have been part of the reason for the Senecas' withdrawal from the Board. Furthermore, the Longhouse people in general had apparently accepted very few Western medical beliefs and practices at this point, and since the belief system underlying the duties of the Board of Health included ideas of natural cause and effect regarding illness, the Senecas' refusal to participate might also have been motivated by these discordant medical ideologies.

Moreover, throughout the history of membership in the Board of Health, of the total of thirty-four Chiefs at one time holding office, only five were Longhouse. No Longhouse Chief was ever secretary or chairman, although conservatives did participate in the functioning of the Board, and one Chief in particular, Jacob General, was a member for seventeen years (1903-1920).

The office of secretary was first held by Nelles Monture, at one time a leading figure in the Warriors' Association. From 1903 until 1914 Chief J.W.M. Elliott, a well-educated man who after some training in law, worked as a newspaper reporter for the Toronto *Globe*, occupied the position. Another Chief who stood out as a permanent figure of the Board was J.C. Martin. He became chairman in 1905, when the office was created, and held that position until 1915. He then became secretary in 1916 and continued in that position until the dissolution of the Board with the change in form of government in 1924.

The regulations governing the composition of the Board were not adhered to after the second year of its operation. The difficulty in maintaining representation of all six tribes was exemplified by the refusal of the Senecas to participate in the first year; after a few years it did not appear to be desired by the Council. A willingness to participate was seemingly the main basis on which candidates were selected. Since the Longhouse did not "put themselves forward," few conservatives were members. Of the thirty-four Chiefs who at one time were members of this Board, twenty-six of them held tenure for periods of one, two, or three years, but the original system of office tenure rotation was not consistently followed. Deviation from the regulations regarding composition and tenure had, however, little effect on the stability of the Board. Since at all times there were both new recruits and older experienced members, a certain continuity to the group's operations was maintained. In many cases, for instance from 1908 to 1911, the entire membership of the Board was "reappointed" for the year that followed.

The full complement of six Chiefs for each year was consistently maintained until 1921, when the Chiefs' policy of non-compliance with the Indian Department began to produce very strained relations. In 1922 and 1923 the Board was composed of only four members, and in the following year only three were appointed. This dwindling of membership reflected discord with the Indian Department, but there is little evidence in the Council Minutes of a diminishing of interest in the members' duties. In the Board's annual report for 1921 concern for their responsibilities is very evident.

Ohsweken Council House
January 4, 1922

Report of the Six Nations Board of Health for the year just ended December 30, 1921.

To the Chiefs of the Six Nations Assembled.

> Honorable Sirs,
>
> We the members of the Six Nations Board of Health do humbly give a partial report to your Honorable body for the year just ended as described above.
>
> The members of the Board of Health are somewhat handicapped in giving a full report of the different nature of diseases occurring throughout the Reserve for this reason the supposed appointment of the Medical Health officer by the Civil Service Commission who by the way have no jurisdiction in making such appointment. The Six Nations having a head governing their own internal affairs having a territory ceded to them by the British Crown cemented with a Deed and they become absolute owners and their posterity are to enjoy forever.
>
> Therefore your Board of Health cannot co-operate with such appointment which was not made by your special right and privilege. But in spite of all this your Board of Health is duty bound to state before your honorable body what transpired throughout the year just ended. It might be interesting to you to know the manner in operating the machinery of your Board of Health. The Board met 19th January 1921 and divided the Reserve into six divisions each member was allotted to one of these divisions so that the populace would have better facilities to reach a member in the division which they belong (Minutes, January 10, 1922, p. 165-166).

The subsequent termination of the Board of Health makes it impossible to assess any benefits that may have resulted. But the division of the reserve on the basis of locality rather than tribe was only one of many indications of the decreasing significance of the tribal unit in reserve affairs. The divisioning itself, moreover, appears to have been the idea of the members of the Board without prompting by outside authorities.

In comparison with the ideal duties of the Board originally laid down in the bylaws, the actual duties tended to centre on a few of those prescribed, while others were sporadically undertaken or completely neglected. Toward the final years of the Board's existence there was an increasing tendency, largely because of Council directives, to branch out into new areas of responsibility not included in the regulations.

The inspection of ice and foodstuffs sold on the reserve was attempted once, according to the Council Minutes, but with rather embarrassing results. A store owner in the village of Ohsweken was accused of having for sale "diseased pork which the Board of Health condemned as unfit for food and . . . confiscated to be destroyed" (Minutes, May 6, 1903, p. 541). The accused was given opportunity to present his case in Council, whereupon the Chiefs decided that legal counsel should be obtained from the Indian Agent, who was then absent from Council. A Sanitary Inspector for the County of Brant was also called in to examine the pork; his report stating that the meat was fit for human consumption was adopted by the Chiefs, and the accused storekeeper was "exonerated." The position of Sanitary Inspector allowed for in the Act had never been filled, apparently because of the lack of qualified personnel on the reserve and of the reluctance to expend band funds on employing such personnel. The enforcement of regulations that required specialized knowledge, such as this instance, was a duty for which the laymen on the Board were ill-equipped. This unpleasant experience so early in the Board's history served to stress the need for qualified personnel. Since none were immediately available, this rule was no longer enforced.

The Board handled few complaints of health hazards, although one informant recalls the Board members "telling people to clean up their yards." Soon after the Board's inception attempts were made to prevent the pollution of water sources on the reserve by having section 42 of the Act printed and distributed to the people. Concern, demonstrated earlier, about the pollution of the Grand River from upstream sources was manifested by the Board on several occasions, but it was beyond their authority or influence to alter the situation. There is little indication that the regulations specifying the depths of graves and confining burials to established graveyards were enforced although they may well have been. The prescribed public meeting to explain the functioning of the Board of Health does not appear to have been held, although it may have occurred at the time the Medical Superintendent gave public lectures on the general state of health on the reserve. On only two occasions, in February of 1908 and 1912, did the Medical Officers deliver public addresses at the Board's request. It may well have been this lack of communication with the people about the duties of the Board that is responsible for the fact that few of the older people on the reserve are aware of its past existence, not to mention its duties.

The Board was most conscientiously active in the control of contagious diseases. They cooperated closely with the Medical Officer in fumigating houses in which contagious diseases had broken out. In fact, the few annual reports of the Board recorded in the Council Minutes are little more than lists of the diseases most prevalent on the reserve in that year. Assessments of the "sanitary conditions" of the community and of precautions needed, theoretically to be part of these reports, were never made. As another control measure, placards with common diseases printed on them were requested from the Indian Department throughout this period from 1900 to 1927. Quarantining was also undertaken, and although the members did not themselves act as guards, they hired the men and in joint action with the Medical Officer prohibited public gatherings during epidemics.

The concern of the Board of Health about sanitation in housing was demonstrated soon after the Board was set up. In 1902 the Board recommended to the Council "that the loan system might be extended to the building of dwelling houses, with a view that there may be more rooms in the houses and that better ventilation and light be secured, and thereby the conditions of the health of the people may be improved" (Minutes, March 12, 1902, p. 447). The Council "unanimously approved" their recommendation, but six years later the loan extension was still not a reality, as is evident in the following resolution:

> The Council further decided to ask Doctor Bryce to use his influence as Chief Medical Officer with the Department of Indian Affairs to confirm the decision of the Council asking for an increase of the loan fund to $50,000.00 to enable the Council to loan money to their people for building houses on a more sanitary basis so that the people may be assured of better health conditions as Dr. Bryce says that that is the fountain head from which point all diseases should be combated (Minutes, May 11, 1908, p. 34).

House building loans from the Council were not made possible during the remaining period of hereditary government on the reserve, despite the efforts of the Board of Health and the Council.

One of the new responsibilities assumed by the Board, arranging for the care of sick persons lacking immediate families, became increasingly important during the last few years of the Board's existence. In some cases a member of the Board was assigned as "guardian" by the Council along with one member of the sick person's more distant relatives, and together they made arrangements for proper medical care. If no relatives were available, two members of the Board were allocated the responsibility:

> G.G. helpless invalid.
> The Council decided to instruct Chief J.C. Martin and Peter Froman, members of the Board of Health, to make some arrangements for his proper care and maintenance during his illness as it [*sic*] is reported to be alone and suffering gangreen [*sic*]. The Secretary to issue a relief order of $4.00 should it be required upon the report of the Board of Health (Minutes, July 24, 1923, p. 330).

The board was also sometimes asked to inquire into the need of individuals who had requested pensions from the Council because of old age and (or) infirmity. This investigating was usually carried out by the Medical Officer, but the Board was asked to participate when the Council wanted double assurance that the pension was definitely needed. Finally, when individuals died without immediate families or relatives to arrange and pay for the cost of burial, the Board was requested by the Council to undertake the necessary burial procedures.

The Council passed on these extra duties to the Board of Health only when the sick or needy individual had no immediate family to assume the tasks. Such personal welfare assistance had been traditionally the obligation of the matrilineal extended family and the clan, but with the gradual retraction of clan functions and the disappearance of the larger family unit the Chiefs had begun to fill this role. By the 1920's the Council had delegated these tasks to the Board, whose regular operations were often not far removed from the realm of social welfare.

The relations between the Board of Health and the Council were, on the whole, harmonious. The salary for the secretary of the Board was regularly allotted to the office holder, and the members themselves who, according to the regulations, were to act "without remuneration" received a small stipend from the Council. In 1908, for example, they were awarded "$2.00 each for their assiduous attention to their duties and as a small compensation for much valuable time sacrificed by them in carrying out their regulations" (Minutes, January 10, 1908, p. 440). Fumigators were purchased for the Board on several occasions, and the accounts were readily settled by the Council.

The Council in delegating these extra duties to the Board was consistent with its position that, beyond the family unit, responsibility for the health and welfare of the people rested with the Chiefs. Unlike the previous period, however, the Chiefs did not include friendship ties within this sphere of responsibility. The nuclear family and bilaterally defined kindred were the social units responsible for care of the sick and the infirm. This definition of the locus of responsibility was explicitly stated in the Council Minutes when an issue arose regarding the acquisition of new clothing for a man who had been sent to the Epileptic Asylum in Woodstock. The Chiefs appointed a member of the Board of Health and a relative of the individual as guardians, who were "hereby required to raise the amount [for the clothing] from the relatives of the said R.L. both on the *paternal* and *maternal* side of his relatives and *refund* the money to the band" (italics mine) (Minutes, March 4, 1909, p. 194). Hospital and medical accounts for treatment received outside the reserve were likewise considered the combined responsibility of the family and the Council, and the cost divided equally.

In reviewing the activities of the Board of Health throughout its twenty-three-year history, it becomes evident that those duties most consistently and conscientiously performed centred on the prevention of the spread of diseases. Efforts to alter the sanitary conditions (or lack of them) were only sporadically attempted; the issue of well-building, which proved so unsatisfactory in Dr Secord's time, lay dormant; attempts to make funds available for the building of houses proved to be disappointing, and an effort to enforce the regulation concerning foods sold on the reserve turned out to be embarrassing.

The Board of Health was originally patterned by the Chiefs themselves on an outside model of a health organization. The fact that they selectively determined both its organization and duties made for potentially greater harmony in its operation within the existing sociopolitical system of the reserve. And once the Board began to operate, it was given sufficient freedom within the sociocultural system of the reserve to adapt both its organization and its duties to the local setting. Significantly, this pressure to adjust did not originate in the Indian Administration to which the Chiefs were antagonistic, but in the local setting itself. The pressure arose, moreover, from both within and without the Board organization itself, and the members coped with it by both eliminating the enforcement of regulations that required specialized knowledge for which they were not equipped and increasing their reliance on a local source of specialized knowledge, the Medical Superintendent. Extra responsibilities assumed by the Board at the Council's order were simply old responsibilities allocated to a new sociopolitical unit. Furthermore, the enforcement of any of the regulations was left entirely to the choosing of the Board. Areas of concern about public health were determined by the Board itself, not by the Medical Officers, who were noticeably dissatisfied with the lack of enforcement of the Act. In summary, it is evident that the Chiefs, including the Board of Health members, were allowed to structure the public health administration of the reserve themselves. The opportunity to plan policy and carry it out as they saw fit was compatible with their determined political goal of gaining some degree of autonomy over reserve affairs and, as a result, the newly established Board of Health functioned harmoniously within the sociocultural system.

Coterminous with the fate of the hereditary form of local government in 1924 was that of the Board of Health. Although a Sanitation Committee composed of three Councillors was appointed by the elected Council in its first year of existence, this committee was defunct by the second year, and the bylaws that governed the Board of Health were not subsequently enforced.

The tent hospital, 1908-1913

Although it had been difficult to obtain approval for the establishment of the Board of Health, its eventual operation was rather quiet. In contrast, the tent hospital, the proposal for which was immediately accepted, was the centre of stormy controversy throughout its short-lived existence. Figuring largely in the original acceptance of the "cottage for consumptives," as in any idea introduced to the Six Nations, was the personality of the individual proposing the change and his attitude toward the Six Nations. It is obvious from the Council Minutes that this particular physician had favourably impressed the Chiefs.

> Before any business was taken up Chief Thomas Wm. Echo on behalf of the Council arose and tendered Dr. Bryce address of welcome according to the custom of the Six Nations. The Council was pleased to welcome Doctor Bryce who was protected by the Great Spirit from all harm in his journey coming here and now they would like to hear what the Doctor had to say.
>
> Doctor P.H. Bryce then delivered a lengthy speech and before taking up the question of business which brought him here he informed the Council that he is an old Brant County

> boy but one kind of business or another and sometimes at the University kept him away from his native Country for forty years or more. He also mentioned that his dear mother had a friend an Indian woman by the name of old Angeline he would like to know her full name. She came and visited his mother often etc., and this is the first time he had ever entered the Council House of the Six Nations and he hoped this would not be the last time. He referred in course of his remarks to the lasting loyalty of the Six Nations to the British Crown and that they were given this Reserve as a reward for their bravery and allegiance. (Minutes, May 11, 1908, p. 34).

After this introduction Dr. Bryce presented to the Chiefs two alternative types of hospital structure, tents or a small permanent "cottage," and the Chiefs chose the former. A committee of three Chiefs was then appointed to select a suitable site for the hospital, and in two months' time they purchased a two-acre lot adjacent to the Medical Officer's residence in Ohsweken, where, in addition to the close proximity to the physician, a gas line and a deep well were accessible.

Two bell-shaped tents were erected shortly afterward, one to house men and the other to house women. A kitchen was built for meal preparation by a matron, and the one registered supervising nurse was quartered in a smaller tent. All the tents were double-walled for greater insulation and were heated in the winter, apparently none too comfortably, with wood-burning stoves.

As there are few today who remember the tent hospital operations to any degree, what the Six Nations reaction was to these new facilities is now difficult to obtain. The monthly reports of the physicians read in Council meetings and briefly recorded in the Minutes do, however, provide some indication of the attendance, and for a five-month period there is some evidence of the illnesses treated.

The total in-patient attendance in any one month between June 1910 and March 1913 fluctuated between three and ten, with four to six being the average number of patients for most of these months. Attendance of men and women, which was about equal, averaged two to three patients in each of the large tents (17½ by 30 feet) by no means near the possible capacity of the structures. At no time, however, during this thirty-two-month period was the hospital empty. No children were ever admitted as patients to this hospital, nor were out-patients treated there, the latter being tended to in the physician's office. Only eight deaths of in-patients were recorded throughout this time. Although the patients' length of confinement in the hospital cannot be determined from the reports, it becomes apparent, by comparing the number of patients in the hospital in any one month to those leaving during that month, that slightly over half the patients remained in the hospital until at least the following month and possibly longer. There is no indication in these reports of the number of patients who left the hospital without the agreement of the medical staff.

The diseases treated in the hospital can be discerned only for the period from January to May of 1911. During this time three individuals were treated for chronic Bright's disease (nephritis), one woman for cancer of the breast, one man for a fractured tibia, one woman for gallstones, one adolescent boy for pneumonia, and seven individuals, ranging in age from 13 to 44 years, for tuberculosis. Only one childbirth was recorded during this period.

Although the tent hospital was originally intended to house tubercular patients (fifty active cases existed on the reserve when it was first built), persons with other diseases and injuries received treatment there. It was this non-tubercular treatment that eventually became one of the Chiefs' reasons for abandoning the hospital. Only a few of those with tuberculosis, granting that some would be already in sanitoriums, actually utilized the tent facilities. Judging from the reports, moreover, the short-term periods of hospitalization would seem to indicate that these patients did not remain under a physician's care long enough to effect a possible cure.

For the first two years of the tent hospital's existence, for which there are no medical records, the Six Nations Council was satisfied with its operations. The low attendance at the hospital, a predicted reaction from the people, was accepted by the Chiefs as inevitable during the early stage. But the Chiefs did expect that use of the facilities would increase as the people became accustomed to its benefits.

Desiring to have some influence in the management of the hospital, the Council selected, on the same day the site for the tents was chosen, three Chiefs to form a Hospital Committee and outlined the Committee's duties as follows:

> The Hospital Committee shall ascertain the amount of cost or the expenditure in connection with the building of the kitchen for the hospital and all other costs in this matter, and that the Council hereby authorize the said Hospital Committee to assert the rights of this Council in connection with the appointments of the Officials and that they will continue to act with the Medical Superintendent in all things touching the conduct of the said Hospital, and that they will regularly, and fully report to the Council at the proper time with reference to all appointments, salaries or wages paid or to be paid and that all the attendants including the matron and nurses be appointed by the Board as far as possible (Minutes, August 5, 1908, p. 74).

In January of 1909 the Council gave the Hospital Board the additional duty of "act[ing] together with the visiting Supt. and the Medical Supt. . . to see that the patients are well and comfortably cared for. . ." (Minutes, January 6, 1909, p. 156). Of the seven Chiefs who at some time held office on the Board, all were Christians and well acculturated, and three had been members of the Board of Health. But, to the Council's annoyance, the desired influence of this Board in the administration of the hospital was never achieved, and this in part contributed to the eventual pressure to "do away with the hospital."

It was not from the Hospital Board that pressure to establish a permanent hospital arose but from the Board of Health. The annual report of the Board of Health in January 1910 recommended to the Council the building of a permanent hospital structure, but this was not agreeable to the Council as a whole, and the issue was to be "considered more fully later on" (Minutes, January 4, 1910, p. 403). That spring, public dissatisfaction with the hospital prompted the Chiefs to pass the following resolution:

> The Council after some discussion among the Chiefs refused to vote any more money at present towards expenses for further improvement on the Hospital buildings, until they are better satisfied that the people of the Reserve appreciate the benefits which said Hospital can afford towards relieving our sick people &c. There has been too many complaints up to the present time, and it is the duty of the Council to look into it closely and find out the cause for such complaints (Minutes, April 10, 1910, p. 459).

When the next annual report of the Board of Health again recommended the building of "an addition to the hospital," it was accorded the same reception by the Chiefs, who felt that "the people of the Reserve don't seemed [*sic*] to appreciate the Hospital enough" (Minutes, January 6, 1911, p. 138). In May of 1911 the Council "decided to dispense with the services of said Hospital upon the following grounds: that it is costing to [*sic*] much money to keep it going for the good it is doing and does not satisfy the people as to the results" (Minutes, May 10, 1911, p. 231). The "wasteful expenditure of the people's money in sustaining the Hospital," did continue, however, despite the fact that the Council claimed that "people refuse to come to it at present."

Aggravating the situation in the summer of 1911 was the refusal of the Indian Department to forward to the Chiefs the list of names of prospective new Medical Officers for the reserve. In addition, the collapse of the women's tent in a severe windstorm in July caused the patients no little concern and made necessary the purchase of a new tent to replace the one that had been damaged beyond repair.

During the next year the Council reconsidered the issue of a permanent hospital and the closing of the tent hospital. Some of the Chiefs were in favour of maintaining these facilities in order to give the people time to adjust to the idea, but others were strongly opposed. The public's continuing reluctance to use the hospital and the inability of the Hospital Board to exert any influence on the Department of Indian Affairs over its administration finally resulted in Council's decision to close the hospital in the summer of 1912. In considering this issue the Chiefs had looked beyond the bounds of the reserve to adjacent areas for the existence of hospitals. This was their final decision:

> The Council was forced to come to this conclusion after carefully judging the surrounding County, say for instance the Counties of Haldimand, Norfolk and Oxford, rich and thickly populated Counties, but they have no Hospitals and the Government do not seem to exercise any authority to compel these people to put up Hospital buildings. Why therefore should the Six Nations be compelled to go to that expense when they are only a little over four thousand all told, and nearly one third of these are continuously away from home working among the Whites . . . With regard to our sick people who would require Hospital treatment in the future we can return to our former system and that is to send them either to Brantford or Hamilton (Minutes, July 2, 1912, p. 467).

Two Chiefs were asked to undertake, with the assistance of the Indian Agent, a comparison of the cost of running the Ohsweken tent hospital with that of the Brantford Hospital. Despite the difference in operating cost, these two Chiefs still recommended that the reserve hospital be abolished. In January of 1913 the Council reinforced their decision of 1912 by refusing to appoint a Hospital Board, which in any case had had very little power. The Indian Department did not act, however, until March of 1913 to actually close the hospital and remove the tents.

The history of the attempt to establish a hospital on the reserve serves as one more indication of the close association between medicine and politics among the Six Nations. When the Chiefs were given the opportunity to participate directly in measures to alleviate and prevent illness in their community, as in the case of the Board of Health, they accepted; they acted conscientiously in areas where they saw the necessity, and the Board became a stable part of the political and medical spheres of reserve life. When changes occurred in the administration of medical matters on the reserve in which the Council's participation proved ineffective, such as in the choice of physicians and the management of the hospital, dissidence arose that culminated in Council's withdrawal of cooperation.

As will become evident in the discussion of the next period of medical administration (1927-1950), the first quarter century marked the peak of Council participation in medical matters on the reserve. With the advent of the elected Council came the establishment of the Lady Willingdon Hospital and the beginning of a separation of local politics and medicine. Much of the political unrest in the Six Nations sociocultural system terminated in 1924, at least overtly, and until 1950 political concerns, which had so adversely affected medical matters in the past, ceased to influence the operations of either the hospital or the physician.

Unlike the previous medical period, this one was generally characterized by a high degree of permanence of the medical personnel and facilities locally available to the Six Nations, and by a noticeable and abrupt withdrawal of band Council pressure to influence medical matters on the reserve. The Council still approved pensions and welfare assistance for the needy, however, and paid half the authorized hospital and specialists' accounts from outside the reserve. But beyond these duties, the Council tacitly agreed that the administration and practice of medicine rested with the physicians and the Department of Indian Affairs.

Face-to-face relations between Councillors and individuals in times of illness, as the Board of Health had effected, no longer occurred. By the 1940's the communicable diseases of much concern to the members of the Board of Health, such as smallpox, diphtheria, scarlet fever, and typhoid fever had diminished in prevalence. With the development of effective vaccines and antibiotics, and with the discovery of insulin for diabetes and chemotherapy for tuberculosis in the early 1950's, the physician's ability to prevent and treat disease was greatly enhanced (Ackerknecht 1955: 212-223). This period of history was, in general, one of great advancement in the science of medicine, and on the reserve it was a time of satisfaction with the medical services and facilities.

The establishment of a permanent local medical institution, the Lady Willingdon Hospital, and the presence of trained personnel recognized as better qualified to perceive and cope with the health needs of the community were in large measure responsible for the relinquishing of Council responsibility for the health of the people. The Federal Government's suggestion that a hospital be built received immediate approval from the elected Councillors on the condition that the cost be shared by the Indian Department (Minutes, May 6, 1926, Res.7). The Six Nations contributed approximately $7,000 toward the building; the Indian Department more than doubled this sum, and from that point on it carried the costs of maintenance and medicines, which in the early years of operation amounted to $3,000 to $4,000 annually (Agency Shannon File "New Hospital Reserve, 1927-1930," March 16, 1928). The Six Nations, however, continued to contribute to the physicians' salaries until 1953 when the hospital was reorganized.

In the first stages of planning for the hospital the Council participated very little and had apparently no desire to do more. Although one Councillor did propose that a Hospital Board with Council representation be set up to act in the Six Nations interests, this idea was not favourably received by the Indian Agent, and the issue was pursued no further by the Council (Agency Shannon File "New Hospital Reserve, Jan. 1927-1930," Jan. 1928). Whether the Council as a whole supported this one Councillor's proposal is not mentioned in the Minutes; what is certain is that the Indian administration preferred to manage the hospital without local participation. Shortly after the hospital opened, some Six Nations women offered to assist the hospital staff with sewing and mending; later, members of some interest groups wanted to plant trees on the hospital grounds. Neither these nor other offers of local assistance were ever accepted by the senior physician.

The two-storey hospital, containing approximately twenty beds, was erected in 1927 adjacent to the physician's residence in Ohsweken. Two physicians (the Medical Superintendent and Assistant Physician), a head nurse, and two assistant registered nurses comprised the

Plate V. Lady Willingdon Hospital when built in 1927. (Courtesy Mr. and Mrs. Roderick Hill).

Plate VI Lady Willingdon Nursing Home, 1969

medical staff. The maintenance staff of a housekeeper, a maid, and a janitor-handyman were all Six Nations people, and one of the assistant nurses hired in the second year of operation was a Six Nations registered nurse.

Although this period was relatively quiet politically, the bitter feelings of some toward the Federal Government over the removal of the Chiefs were not without effect on the Six Nations reaction to the new hospital. Nor were the Six Nations nationalistic pride and consciousness of their unique status in relation to other Indians to be discounted. This pride was manifested in a small incident, which took place shortly after the hospital opened, when the first baby born in the hospital was to a "foreign" Indian, a Chippewa woman from the New Credit Reserve. Dr. Davis had approached several Six Nations women soon to give birth asking them to come to the hospital for their confinement, but all had refused. One Councillor's attempt to restrict the hospital to the Six Nations alone on the grounds that it was Six Nations money that had built it was unsuccessful, however, and to the present day Chippewa patients have been admitted, as have Indian children from northern Ontario, and Eskimo children more recently. And there are still some today who object to non-Iroquois admissions, as they do to the admitting of "foreign" Indians to the Mohawk Institute in Brantford.

At first some were averse to using the hospital, and many agree, as one informant claimed, that it was "just because of silly things, like people saying, 'It's the government you know.'" Another informant recalled a case of an old woman who was living alone although she was bed-ridden. She had refused to go to the hospital despite the urgings of an Onondaga storekeeper and other Six Nations people who were concerned about her condition. The informant was called in to try and persuade her, but he too failed. He remarked afterwards "some Indians wouldn't go to the hospital no matter how sick they were." This woman apparently would not go because of the "petty" stories that had been circulated against the hospital. Still another informant pinpointed this reluctance to the conservative part of the population: "The Longhouse people were suspicious. They wouldn't go to the tent hospital either." Although the conservatives were reluctant to use the hospital facilities, and this reluctance applied to childbirth as late as the 1940's in some cases, it is doubtful that the "hospital stood empty for a full five months" after it was built, as some claim. On March 13, 1928, for example, a few months after it was opened, the hospital was "chuck full" of patients, according to the Indian Agent (Agency Shannon File "New Hospital Reserve 1927-1930"). In that same month, validating this account, the Medical Officer wrote a letter to the Indian Agent in which he stated that "the average number of patients is 17" (Agency Shannon File "New Hospital Reserve 1927-1930," March 30, 1928).

Easing this transition to a hospital setting for treatment was the fact that hospitalization itself was not a new experience for the Six Nations. An additional factor, and equally significant, was the familiar figure of the senior physician, Dr. Davis, and the presence of Six Nations people on both the medical and the maintenance staffs. The head nurse had also been well liked by the people when she was associated with the tent hospital, and neither her role nor her personality was novel to the Six Nations.

Plate VII. Doctor's residence built in 1885 and renovated in 1968 for the Six Nations Public Library. (Courtesy Chief Councillor Richard Isaac)

Of no slight importance, moreover, in the Six Nations adjustment to the new hospital was the fact that those who refused to go to the hospital at the physician's request were not alienated by the medical staff. If persuasion failed to bring them, the physician treated these persons either in their own homes or as out-patients. It was largely on the basis of this flexibility and self-sacrifice in the physician's performance that the present-day ideal model of a physician's role is founded. This role model, furthermore, was patterned predominantly on the activities and attitudes of one doctor, Dr. Davis, who served the Six Nations for over thirty-five years.

When Dr. Davis was an infant, it is said, his white parents abandoned him on the doorstep of an Indian home on the reserve, and an Indian couple raised him. He went to public school on the reserve and as a teenager walked several miles to attend high school in one of the nearby towns. After graduating from the University of Toronto medical school, he began practising medicine on the reserve in 1914. Although he was "never put on the band list," Dr. Davis was considered a member of the Six Nations community and, because of his education and humanitarian service to the people, was respected and admired. In spite of his being white, "he was different." "People didn't consider him a white man. He was one of us."

As a physician, he is best remembered in the "horse and buggy days" when "he would always come when you called at any time of day or night. You could always depend on him." It is said that he knew the people who made unnecessary demands on his time and energy, but it is seldom stated that he refused to make future calls in these cases. Despite the better facilities available for treatment in the hospital, reticence on the part of an individual to utilize these facilities was not met with a denial of his assistance. This continued willingness to inconvenience his personal life in the service of others was a very important indication to the people of Dr. Davis's devotion to duty.

Assessment of his medical knowledge and skill is usually phrased in such terms as "He was smart for his day." An assistant physician to Dr. Davis, a Six Nations man, thought very highly of his obstetrical skill, and some people cite this physician's opinion when commenting on Dr. Davis's capabilities. It is stated, although only after his positive qualities have been given, that he was "a little behind the times" near the end of his career, "he wasn't right up there in medicine," but this limitation is minimized by a signal value in non-conservative culture, that of doing one's best in any endeavour under the given circumstances. The fact that he was not a licensed surgeon and therefore was dependent upon referral services for the more complex types of surgery is also known by most people, but it is not considered to have detracted seriously from his reputation.

Despite the minor limitations of his medical knowledge and skill, one seldom hears unfavourable comments about this physician because it was felt "he tried, he tried his very best." Described as a "seemingly patient" man, he was said to be a "good doctor" because, as one informant phrased it, "he could take control of any situation and calm the nerves of the loved ones." Giving direction in a time of crisis and demonstrating personal concern for the patient and his family are considered by the Six Nations to be of paramount significance in a physician's role performance.

Plate VIII Dr. Walter Davis who served the Six Nations from 1914 to 1920, and from 1924 to 1950.

This element of "sympathy," moreover, has been a longstanding requisite for a desirable doctor-patient relationship, for it was referred to several times in the period between 1900 and 1927, when dismissal of doctors was attempted by the Council.

Another expectation of a doctor's performance is that he "should explain what is happening and what they [the family and patient] can do to help." The role of the family in helping the patient regain his health was, and still is, felt to be a strong reciprocal obligation. The ability of the family members to fulfill this obligation depended on the good advice of the physician. If his advice were followed without perceived satisfactory results, then annoyance with the physician might develop. One informant, in discussing Dr. Davis, stressed the fact that the doctor would cancel a prescribed medication or regimen if it were not producing the desired results, instead of persisting, as some physicians do, in its application "until it killed the person."

Dr. Davis's popularity on the reserve arose from many factors, among which was a certain understanding of medical beliefs and practices of the Longhouse people. It is claimed by many conservatives (and non-conservatives) that "when his medicine didn't work, he'd tell us to use our own medicines." Since he would naturally be familiar with some Longhouse customs, though it is doubtful that he had a very sound knowledge of them, his directives to resort to Iroquois methods indicated to the more traditionally oriented individuals that he had a certain appreciation of and respect for their beliefs. It was undoubtedly his perception of the importance to the Longhouse people of their medical beliefs that was responsible for the comments of one very strong Longhouse adherent, for example, who described him as a "great doctor" who "had the confidence of all the people." Another informant, whose mother was a conservative and a well-known herbalist, recalled that Dr. Davis had recommended a "pig head feast" for a certain illness, and though she added that she had never heard of such a feast, she acknowledged the fact that feasts "do help" but do not necessarily "cure" sickness. In another instance, when the Spanish flu was prevalent on the reserve, this same informant recalled the doctor's coming into their home and smelling the odour given off by elecampagne (*Inula helenium*) boiling on the stove for her father who had contracted the flu. She said that the doctor commented, "That's good stuff; give him all he can drink." In addition to recognizing the utility of traditional curing methods in some circumstances (i.e., for Longhouse adherents), he apparently seldom failed to legitimize the role of patient (Parsons 1964: 436). In prescribing pills and vaseline and in recommending feasts to the Longhouse people, he acknowledged the psychosomatic aspect of illness, a very important facet of the conservative definition of the health-illness complex (Shimony 1961: 261) and, to a lesser extent, of the non-conservative definition. As one non-conservative informant remarked, "He'd use psychology. He'd give you any darn pink pill. He'd joke with you and tell you that half of it was in your head." The prescribing of medicines or feasts, despite references to the individual's imaginative powers, reinforced the person's belief that he was indeed ill, and that the doctor "cared" to realize this and acted with the patient's best interests in mind.

Dr. Davis was fully aware of the multiple roles he performed in the reserve community, for in a letter to the Indian Agent in 1924 he wrote as follows:

> I am sure it is difficult for an outsider to realize the responsibility connected with this office, where one must act as health officer, Doctor, relief officer and sometimes also as spiritual adviser (Agency Shannon File "Medical Supt Jan 1924–Dec 1928," March 23 1924).

To this list of roles were added those of hospital administrator in 1927, and notary public in 1928, and he performed all roles to the general satisfaction of the Six Nations people. When there was sufficient doubt about his competence as a physician, medical assistance was sought in the surrounding towns, often from physicians who had served in the past as assistants to Dr. Davis.

Dr. Davis, furthermore, was not simply a white doctor practising on the reserve, for he was recognized as an active participant in the life of the non-conservative community. He and his family attended and supported the church; his children were raised on the reserve and attended the public schools with Indian children. Two of his daughters worked at the hospital; one in the capacity of housemaid shortly after the hospital opened, and the other as a public health nurse in the early 1950's, the first to hold this position on the reserve. At his death in 1957, some seven years after retirement, he was buried on the reserve although he was never legally a Six Nations band member. This was the final declaration that he indeed was not considered an outsider.

Dr. Davis has become a legend, particularly among the conservatives. The ideal requisites of a good medical doctor—medical knowledge and skill, self-sacrifice, personal concern for the patient, giving of advice to the patient's family, patience, ability to direct action at a time of crisis, and legitimizing of the patient role—were in the general opinion of the Six Nations present in Dr. Davis. There was no strong element of charisma attached to the role of physician by the non-conservatives, but a situational charisma could be said to have existed. That is, the social context in which he lived and worked was extremely receptive to his demands and appreciative of his services. The physician's role that he carried was seen to rest on long-term specialized training and conformance to certain standards. Although only the more educated and acculturated persons actually knew the training required of a physician, the majority of people understood that certain requisites had to be met before one could take up the practice of medicine.

Although control of the technical aspects is significant in a doctor's role, it will be found later that, of the physician's attributes, that of demonstrating personal concern for the patient and his family and of expending one's efforts to the best of one's ability are equally significant in the Six Nations evaluation of a "good doctor." If a physician evidences concern and expenditure of effort then the people will tolerate a perceived deficiency in the control of medical technology that renders the physician less than ideal. On the other hand, if a physician does not demonstrate personal interest in his patients and does not try his best, even though he may be judged as having control of medical technology, he is found displeasing by many people; he is respected but not liked; and may or may not be consulted. He is subject to criticism, but not to the pressure for his removal from office that occurred in the first quarter of this century. If, finally, a physician is considered devoid of all three requisites, he is the target for much severe censure, and efforts are made, albeit unsuccessfully, to have him dismissed from office.

Dr. Davis's success as a medical man was without doubt a signal factor in the adjustment made by the Six Nations to the hospital setting for treatment. The hospital, which was free of charge to the patients, was presented to the people by a man who was liked as a person and a specialist and was considered one of them (i.e., an insider). Their lack of familiarity with hospitalization for all but the most severe illnesses was overcome because this new aspect of Western medicine was not rigidly imposed on the people but was merely established as another alternative to the therapeutic setting that could be exploited if the individual so desired. Dr. Davis's accommodative approach to the people's use of the hospital allowed for an element of choice, one which over the years made for a smooth transition to very steady use of its facilities. The obliging nature of the physician's role and the small-scale operation of the hospital became the accustomed context in which Western medicine was presented to the Six Nations. When, in the final period of medical acculturation (1950-1966), this context shifted rather abruptly to a no-choice situation, conflict arose somewhat resembling that prevalent in the first quarter of the century.

The Contemporary Medical Period, 1950-1966

In 1950 many far-reaching innovations in the medical facilities and services on the reserve began to be effected. New policies resulted in the alteration of Six Nations access to medical assistance as locally presented; this in turn tended to focus their attention on the role performance of medical personnel, especially of the physicians.

It should be noted, however, that these changes in policy did not cause unpopular public comment to be directed to the nurses on staff. The important attributes found missing from the physician's role performance (i.e., personalized care and sympathy for the patient) were those very qualities that the nurse's role traditionally emphasized. The satisfaction with the nurses' role performance, and their being fully qualified, tended, in part, to compensate for observed or believed lack of similar qualities among the physicians. In addition, the fact that the majority of the nursing staff are Six Nations removed the inter-ethnic element of social and cultural distance between nurse and community.

As was the case with medical changes following the turn of this century, this period of upheaval occurred not in a relatively static sociocultural milieu but in one that was then experiencing many new pressures from the dominant contact culture. Similarly, this was a time of rather widespread political unrest on the reserve, which finally culminated in the 1959 "uprising," an unsuccessful attempt by some Mohawk Workers and Longhouse adherents to depose the elected Council and reinstate the Confederate Chiefs.

During these sixteen years many social welfare services were gradually introduced. Pensions for the aged, the blind, and the disabled were extended to the Six Nations people for the first time, as were the Mother's and Dependent Father's Allowances. To cope with the local administration of these benefits, the position of Welfare Officer was eventually added to the band Council's staff. In addition, the Children's Aid Society of Brant County offered its services to the reserve; with this extension came the establishment of foster homes for Indian children, of counselling facilities, and of other types of aid.

In the more immediate area of medicine, prepaid medical plans came to the fore in the 1950's. In 1956 the Ontario Hospital Insurance program came into effect, and Federal Government pressure was put upon the Council to establish some type of group plan for its band members. For the first time, public health services became an active concern of the Federal Government, and a public health clinic was set up in the hospital to operate a maternal and child health program.

As sanitation became a particular interest of the public health personnel in the Indian Health Services, efforts were made to effect alterations in the local reserve setting by drawing upon its residents for support. A Sanitation Workshop, held on the reserve in 1959, served to stimulate concern with local problems, and from this grew the Health Committee. As a result of the work and interest of this committee, the Six Nations Community Project was organized in 1964 to promote the acquisition of a water system for the village of Ohsweken.

Despite refusal by Mohawk Workers (at least in public) to apply for or accept some benefits, the social welfare services mentioned above were generally considered by the non-conservatives to be changes for the good of the people. This certainly was not the attitude toward the concomitant changes in medical policy and practice. In 1945 the Department of National Health and Welfare assumed medical responsibility for the Indian people in Canada, and a consequence of this change in administration was the modification of medical affairs on the Six Nations Reserve, which began in the early 1950's.

Some of the resulting innovations in medical practices were ultimately derived from the Government's aim "to assist Indians in achieving full status as citizens and in accepting complete integration into the community" (Indian Health Services, "Schedule of Medical Fees," 1962:1). But most of the changes were due mainly to the transformation of the medical institution itself, a transformation stemming from the many advances in medical technology during World War II (Bloom 1963: 17-18), which produced striking changes in the physician's role performance. The discontent that these alterations subsequently provoked on the reserve must, therefore, be understood in the proper social context. The situation involves a group of people who are very sensitive to the treatment they receive from whites, particularly from the Federal Government, and who are also being forced to acculturate to a rapidly changing medical institution. Because of sensitivity about their status, the non-conservatives construed the medical innovations as the result of the Federal Government's purposeful promotion and selective application of inadequate medical care to Indians. These changes were seldom perceived as products of a changing medical complex.

The initial evidence of the new medical program was the reorganization of the local hospital. This was followed by the framing of new policies regarding the type of medical services to be rendered the people. Whereas the first change gave promise of an increase in services and more comprehensive treatment, the policy formations dissipated these hopes.

Following World War II, particularly during the early 1950's, additions were made to the original hospital building that increased its capacity from thirty-eight to fifty-four beds. By 1954 a new physicians' residence had been built adjacent to the hospital by the Indian Health Services, and the old band-owned residence then became the nurses' quarters under the Council's expressed stipulation that, as in the past, "free medical services are given to the Six Nations people" (Minutes, August 19, 1954, Res. 6). The Northern section of the hospital, formerly the nurses' residence, was then turned into administrative offices, the dispensary, and the outpatients' department, leaving more space within the older part of the building to enlarge the bed capacity of the women's, children's, and maternity wards. An addition had already been built to the southern half of the hospital prior to 1954, which now contains the men's ward and the public health offices. Also by 1954 a new garage had been built to house the increasing number of departmental cars used for hospital personnel and public health nurses. By 1955 the maternity ward was reorganized to include bassinets, allowing the infants to be cared for largely by the mothers.

During this period the medical equipment of the hospital was brought up to date. A new anaesthetic machine was purchased, and the older enamel ware was replaced by a variety of stainless steel equipment. The hospital already possessed an X-ray machine and a sterilizer, which were adequate for the small-scale operation of the hospital unit. After the mid-1950's, any additional purchasing of equipment was done simply to improve the quality of what was already available.

Concurrent with the physical enlargement of the building itself came an enlargement of the scope of medical services offered. The small-scale organization of the hospital, with its staff of fifteen to eighteen (*see* Table 1), gave way to a more diversified and specialized type of staff. There was a noticeable increment in both medical and maintenance personnel. Also a division of medical and administrative work was effected to meet the more extensive services being offered.

The duties of the combined medical and administrative directorship, held since the opening of the hospital by a single man, were assigned to two men: the medical responsibilities to a physician on staff, and the business tasks to a hospital administrator. An accountant and additional clerical help were added to the business staff, and a medical records librarian was employed. There was an increase both in the nursing staff and in the number of doctors, with the idea of having four doctors permanently on staff at any one time.

Table 1

Pre-Expansion Hospital Personnel

Personnel	1943	1948	1949
Physicians	2	2	2
Administrative staff	1	1	1
Graduate nurses	2	2	3
Certified ward aides	3	3	6
All other employees[1]	7	7	6
Total	**15**	**15**	**18**

[1] Housekeepers, cooks, and maintenance personnel.

By 1961 the expansion and reorganization program of the hospital building, equipment, and staff had terminated. Additions to the staff were completed despite the frequent turn-over of personnel in some areas. The nurse who had administered the public health program since 1951 was joined in 1957 by a second nurse. Since that time the number of clinic personnel has remained stable. The total number employed at the hospital in 1961 (excluding the public health nurses, who are separately employed) was sixty-five, of which forty-seven or 72.30 per cent were Six Nations people. Although only one of the Six Nations men who have become doctors was ever employed at the hospital (in the 1920's), the nursing staff has been predominantly made up of Six Nations women since 1950. Of the thirteen registered nurses in 1961, for instance, eight were from the reserve, and all the certified nursing assistants, ward aides, housekeepers, and cooks were Six Nations women (*see* Table 2). With the exception of the Supervisor, all the maintenance staff positions were filled by men from the reserve. The laboratory technician and three of the five clerks were Six Nations; only two clerks, the hospital administrator, the accountant, and the Director of Nursing were not Indians.

In 1961 all but four hospital personnel had been hired since 1950. This discontinuity of staff, however, had little bearing on the later rising discontent with the hospital. In fact, it was an advantageous change in that it increased employment opportunities for the Six Nations people, especially their professionally trained personnel.

Following the 1961 peak in hospital expansion both the number of personnel and beds set up for adults and children (not infants) were decreased. The beds permanently set up for use were reduced from thirty-two in 1951 to twenty-six in 1966. Total personnel was reduced from sixty-five in 1961 to fifty-five in 1966. Of these fifty-five persons, forty, or 72.72 per cent, are Six Nations. Despite the fact that the reductions occurred in positions predominantly filled by Six Nations (i.e., graduate nurses, certified nursing assistants, and housekeepers), the percentage of Indians hired by the Federal Government has remained the same.

Table 2

Post-Expansion Hospital Personnel

Staff	Total 1961[1]	No S N[2]	Total 1966	No S N
Medical				
Medical superintendent	1	0	1	0
Medical officers (physicians)	3	0	3	0
X-ray technician	1	0	1	0
Laboratory technician	1	1	1	1
Director of nursing	1	0	1	1
Assistant superintendent of nursing	1	1	—[3]	—
Graduate nurses	13	8	9	7
Dental nurse	1	0	1	1
Dentist	1	0	1	0
Certified nursing assistant	7	7	3	1
Ward aides	5	5	8	8
Administrative				
Administrative officer	1	0	1	0
Department accountant	1	0	—	—
Medical records librarian	1	1	—	—
Clerks	2	0	4	1
Stenographers	2	2	2	2
Typist	1	1	1	1
Maintenance				
Housekeepers	13	13	7	7
Cooks	2	2	3	3
Laundress	1	1	1	1
Maintenance supervisor	1	0	1	0
Utility men	5	5	5	5
Storeman	—	—	1	1
Total	**65**	**47**	**55**	**40**
Percentage of Staff Six Nations		72.30		72.72

[1] Figures for 1961 obtained from Dr F Voget by personal communication dated May 1966
[2] Number of personnel who are Six Nations
[3] Non-existent position

The post-1961 reduction was the result of new policy ultimately aimed at refocusing medical assistance away from the reserve hospital to hospitals and physicians in the surrounding towns. Prior to the advent of insurance schemes, this redirection process was difficult because of the administration's reluctance to place such a "burden" upon the medical facilities in adjacent towns. Aided, however, by prepaid insurance schemes, and inadvertently by the existence of physicians who are unpopular with many Six Nations, there is some indication that this federal goal is beginning to be realized.

Shortly after the hospital reorganization had begun, a new program for financing medical care was initiated on the reserve, causing much apprehension and discord between the Six Nations and the Federal Government. The most discontented were the non-conservatives, particularly the Council as spokesman for Indian rights. It was evident that the Longhouse adherents were also not in agreement with these new financial and administrative policies, but they attempted no resistance directed to change these innovations, nor did they involve themselves in opposition organized by others. This inactivity is probably explainable in terms of their "double security" system and their general disinterest in non-Longhouse community affairs.

In 1956, for the first time in the history of medical administration on the reserve, hospital accounts were sent to patients. Since the Six Nations had settled along the Grand River, doctors' services, medicines, and later hospitalization had been "free," to the extent that an individual who obtained treatment either as an out-patient or as an in-patient was neither required nor requested to pay for these services. Only under circumstances that necessitated obtaining medical services and hospitalization off the reserve was the person expected to reimburse the doctor or the hospital. The Six Nations as a whole, however, did pay for these local services indirectly, through supporting physicians' salaries and purchasing medicines from band funds. As this form of payment was a collective contribution, not affecting the income of the family or the individual, such services came to be interpreted as "free".

Over the years the Indian administration had made substantial contributions, financial and otherwise, to the maintenance of health services on the reserve. Thus provision of these free services had been construed as an obligation of the Federal Government and a right of the Six Nations.

The first indication of a threat to this right to free medical care, the forwarding of hospital accounts to some patients, was soon followed by an explicit presentation of the Indian Health Services' intentions regarding financial policy. In a "special meeting" of the Council in May 1956, a federal officer urged the politicians to promote the idea of health insurance among the Six Nations.

> In his address to the Council, Dr. W. stated that the purpose of his visit was to request and encourage the Indian people to purchase health and hospital insurance. He compared the difference in medical service that the Indian people would receive under a health insurance plan and that which the Department of National Health and Welfare could render due to their limited funds. Dr. W. requested that the Council encourage the Indian people to obtain health insurance and he requested future meetings with the Council in order that they may mutually work out any details in reference to a health insurance plan.
>
> The Department assured the Council that there would be no accounts sent out in the future for medical services rendered until arrangements for a health plan is realized.
>
> Dr. W. stated that he would advise his Department that the Council requests the Department of National Health and Welfare to cancel all past accounts for medical services rendered to the Six Nations people (Minutes, May 24, 1956).

No formal decision was made by the Council at this time. The rendering of hospital accounts did cease for a period, and those previously issued were cancelled. During the next two years, resistance to this proposed infringement on Indian rights mounted among many non-conservatives, but the issue of health insurance still lay dormant at Council meetings.

Precipitating a formal decision by the Council regarding hospital insurance was a letter received from the Indian Health Services in late 1958 requesting the Council to appoint Six Nations persons to carry out a survey on the reserve. The survey was required that fall because of action taken by the Health Services in purchasing hospital insurance for all members enrolled on the Six Nations band list. In order to meet a deadline and to guarantee that all persons would be insured (which would reduce the medical costs of the band), this blanket type of coverage was necessary. Because it lacked information on which to exclude ineligible[1] persons, the government had knowingly insured them. The purpose of the survey was to eliminate from government coverage those who were not entitled to such free insurance.

The band Council responded to this external pressure by declining to appoint surveyors, as the federal officials had proposed. This decision was consistent with the official Council position then taken and since upheld that the Six Nations (and the Indian in general) are not financially responsible for their medical care. Individual Councillors held, and still hold, differing opinions on the stand taken by the Council, but as a body it passed the following resolution:

> Moved by J.S.D. and seconded by H.I., that this Council wishes to go on record, as stating that the Ontario Hospital Insurance Commission Plan is not acceptable to the Council in the present application to the Six Nations Reserve, for the following reasons:

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[1] To be eligible for government coverage an individual must (1) be on a register for an Indian Agency, (2) not have lived away from an Indian community for more than one year, (3) be medically indigent, (4) not be covered by any other agency (i.e., insurance), and (5) be free from third party liability (Indian Health Services, "Schedule of Medical Fees" 1962).

(1) that the Six Nations people are entitled to free hospitalization in the Departmental Lady Willingdon Hospital, situated on the Six Nations Reserve, because of their investment in the original hospital that was built and because of the free use of a Band owned house as a Nurses' Residence, by the Lady Willingdon Hospital on the Reserve.
(2) that there is no provision in the Indian Act, requiring the Indians of Canada, to pay for their own Medical services.
(3) that the economic position of the majority of the Six Nations people, as a result of their limited sources of income, is such, that they are not able to pay for their own Medical expenses.
(4) that this Council is not in favour of a Board composed of local residents, having the responsibility of deciding who is and who is not able to pay health insurance premiums. Carried. (Minutes, December 4, 1958, Res. 8).

The Indian Health Services, although not legally obligated to provide such insurance services, proceeded with survey plans and employed a white minister to carry out the program. His door-to-door inquiry, however, which brought formal protest from the Council a few months after he had begun, was terminated within a short time. This early cessation was the product of many factors: the Council's disapproval of both the issue and the survey, the residents' disapproval, and the surveyor's own belief that the inquiry was of "little value." Surveys as such are sensitive issues on the reserve, and this one, which combined with it the minister's attempt to convince the people that government changes were "permanent" and "beneficial" not unexpectedly met with considerable resistance. In addition, the March "revolution" was in the air, and, the Federal Government, desiring to remove any sources of discord in an already tense political situation, requested that the survey be discontinued. It was never resumed after the "uprising," leaving the majority of the conservatives uncontacted.

At an increasing rate since 1959 the forwarding of in-patient accounts to persons deemed able to pay has been speeded up by the administration. Until May 1965 notifications that the hospitalization coverage of certain persons had been terminated by the Government were also sent out. Spurring additional Council action was a letter of termination sent to the Chief Councillor in 1963. The Council responded by requesting that the Indian Health Services pay the hospital premiums of personnel employed by the Council (i.e., two secretaries, and workmen on the roads). A delegation of Councillors sent to Ottawa again presented this request some months later to the Minister of Health and Welfare, but without success. Although other issues were discussed with federal officers, those pertaining to health were the prime reasons for the visit. They involved, in addition to the hospital insurance question, requests for the removal of a resident physician and for the addition of a geriatrics wing to the hospital. The Councillors gained little satisfaction through this confrontation; since then no Council action has ensued regarding either the physician or hospital insurance.

The most recent move by the Federal Government in its medical self-reliance program was in January 1966. Since then, out-patient accounts have been sent to all who came to the hospital, except women attending the prenatal and the well-baby clinics. Although these accounts vary according to the type of clinical testing required and medication given, the average bill amounts to about $4.00, largely the cost of the doctor's consulting fee. In this regard the Council has made no move to express either approval or disapproval.

Non-conservative response to financing medical care

The response of the non-conservatives in general to the Federal Government's self-reliance financing program has been complex. A signal aspect of their reaction has been the general antipathy toward the Government, which tended to cloud over the issue of the value of insurance itself and, in turn, to reinforce this antipathy. Until 1950 the Six Nations had had an unrequested blanket insurance coverage in the very existence of the physicians and the hospital. Now this security was being removed by the pressure on them to purchase their own insurance and ultimately to redirect their medical needs to the outside community.

The most decisive reaction to the new medical administrative changes was shown by the Council and has been maintained to the present day. Until the 1963 delegation to Ottawa, the Councillors were generally "under the impression," as one politician phrased it, that the Federal Government was legally obliged to provide free medical services to Indians. Finally aware of the legal technicalities of the medical administration, including the fact that the Federal Government is not equipped with a legal means of enforcing payment of either medical bills or hospital insurance, some Councillors inform inquiring residents that "They can't make you pay." This fact is now well known to most Six Nations. Some Councillors, holding the belief that "the government owes it to us," go one step further and suggest that the bills be discarded. Other Councillors, after informing people of the lack of enforcement authority, simply leave the decision to the individual to make, but rarely do the Councillors stress economic independence in this matter as a creditable value.

The basis of much of the non-conservatives' discontent over the forwarding of hospital accounts has been the apparently haphazard method by which the families were judged to be financially responsible for their own medical care. At one time the delegates sent to Ottawa were informed (and through them the Council) that families with an annual income level of $3,500 or under were eligible for assistance. This restriction was not generally public knowledge, nor did it appear to actually operate as the major basis for judgment.

An equally significant reason for complaint was seen in the billing of individuals and in the expectation that certain persons pay for their own hospitalization when they were known to be in a financial position that supposedly could not support economic independence. In one particular case, a person received a very large account for a long period of hospitalization. Because the man was a small independent farmer, who apparently could not pay the account, this was considered an example of the unjust application of the insurance scheme. This particular individual, a Mohawk Worker who had been "in Ottawa fighting for the Indians" on several occasions, made a formal complaint to the administration; as the story goes, the administration "apologized" with the comment that the individual, though not expected to pay the bill, was to realize what it would have been "if he had had to pay for it." Another version of the story is that the administration had "accidentally" sent the account to the patient, when it rightfully should have remained in the hospital files. Incidents like this one have rather wide circulation, especially among the Mohawk Workers, because they manifestly demonstrate the Government's inability to enforce a policy that is resented as an infringement of and threat to Indian rights. To these extremists it is one of the few instances in which Indian rights apparently prevailed in spite of governmental effort to the contrary.

Another issue of contention was that some ex-patients would receive accounts, and others would not. Those with a more egalitarian approach felt strongly that billing procedures should be an "all or nothing" proposition. However, with no legal obligation to pay, there was only the moral obligation, which, if acted upon, would result in financial sacrifice for those without insurance. As one elite informant phrased it: "Why should I pay when my neighbour doesn't, and he has more money than I have?" Since there is great reluctance to divulge whether one actually did forward payment, and records to this effect are unobtainable at the local hospital, the behavioural counterpart of this moral ambivalence remains unknown. Since most Six Nations are now insured, this behaviour aspect is practically non-existent.

A factor of major importance underlying the entire response to the new demands of pre-paid medical plans was the absence of choice, which affected all but those independently employed on the reserve. With few exceptions, those permanently employed off the reserve (and sometimes those temporarily employed) were covered by their employer in a compulsory plan. Prior to the firm establishment of a self-reliance program, there were occasional complaints made to the Indian Agent by labour unions, which disagreed with the exclusion of Indians as contributing members to their group plans, but these complaints have since ceased.

Those permanently employed by the civil service on the reserve were likewise given no selective latitude on insurance programs. The school teachers, the hospital staff, and the school maintenance staff were required to adopt group plans, to "set an example" for the remainder of the community. Similarly, those receiving government pensions and allowances are automatically insured with the provincial hospitalization board. This left uninsured through the compulsory channels the self-employed, the temporarily employed, the unemployed, and those who were retired but not yet receiving old age assistance. These persons were subsequently insured by the Federal Government through the Six Nations group plan.

Although hospital insurance is now compulsory, the agency through which an individual or family is insured provides a useful indicator of their economic status and circumstances. That this insuring agent further reflects socioeconomic differences among the non-conservatives will be shown in chapter five (*see* p. 98). But it is sufficient at this point to indicate the percentage who are dependent upon the Federal Government for such security. During 1965 and 1966, for example, the Agency paid the hospital premiums for approximately 50 per cent of the total of about 1,100 families (Agency Housing Survey, 1967) residing on the reserve (*see* Table 3). This percentage cannot, however, be interpreted as an accurate indication of the number of so-called indigent families. This also includes those who on principle of Indian rights refuse to pay, as well as those who can support their families but only in a meagre fashion. These non-indigents are insured to protect the Federal Government against higher medical costs. Although the insurance records do not note the differing reasons for inclusion in the Agency's coverage, there is little evidence to contradict the assumption that most of these cases are included because of a general low level of income.

Table 3

Indian Agency's Coverage of Six Nations for Hospital Insurance, 1965 and 1966

Year	1965		1966	
Month	Family[1]	Single[2]	Family	Single
January	582	659	550	543
February	573	637	561	536
March	566	639	564	536
April	570	635	566	535
May	566	633	578	534
June	563	635	583	535
July	548	637	587	533
August	550	634	570	531
September	537	636	595	526
October	540	625	596	522
November	538	620	538	486
December	541	523[3]	536	491

[1] Number of families insured by the Agency.

[2] Number of single individuals insured by the Agency.

[3] This noticeable drop in the number of individuals covered by the Agency was due to a change in Ontario Hospitalization Services Commission policy. In November 1965 the age of dependent children covered by a family plan was extended from 19 to 21 years, hence the reduced number of single individuals covered.

The physician's changing role and new hospital policies

The critical period in medical affairs that began in 1956 and diminished in 1963 had many facets and many causes. The most fundamental cause was the sharp break with the accommodating medical tradition of the past with regard to both the physician's country-doctor role and the flexible medical and administrative policies of the hospital.

One further step was taken by the Federal Government in the removal of medical matters from the sphere of the local band Council and band members. The consequent inability of the Council to correct the faults perceived in the new medical policies only further aggravated the crisis, which reached a climax in the spring of 1962.

The first step in the separation of medical matters from local political influence had taken place in 1927 with the quiet allocation of medical concerns to the hospital staff and the Indian administration. At that time the Council still retained some responsibilities: namely, the provision of financial assistance to the sick and the infirm, and the contribution of band funds to the physicians' salaries. In the early 1950's these remaining Council responsibilities were respectively curtailed by the extension of provincial social welfare benefits to the Six Nations people, and by the Federal Government's practice of paying the complete salary of all medical personnel. Thus the basis on which the old Chiefs had felt secure in calling the physicians to task for their actions, that of providing their salaries, was in 1953 permanently removed, but not at the Council's request.

A singularly important aspect of this "trouble," as it is called by non-conservatives, was the perceived contrast in medical services between those presently offered and those available in the past. Rendering this contrast more vivid was the fact that although the hospital had been expanded and reorganized, the medical care received was not so satisfying as it had been. As will be evident later (*see* Table 9), there was no decrease in the number of patients treated at the hospital, and the treatment included access to more up-to-date technical equipment and physicians. It was the changing qualitative nature of the treatment that led to the intense dissatisfaction.

For the first time, the extension of medical services into the community in the form of house calls was being restrained. In 1952, for instance, 1,451 house visits were made; by 1962 this figure had been reduced to 249, and in 1966 only 14 house visits were made.

The hospital's policy of reducing patient-doctor contact in the home stemmed from several practical considerations: the long distances involved; the amount of time thus spent, sometimes preventing the physicians from completing their rounds; the fact that some calls were unnecessary from their point of view (e.g., arriving at a patient's home to find no one there); and the preference for treating patients in the hospital where the facilities and services for diagnosis and care are superior to the home setting. Behind these reasons, of course, was the new policy designed to shift Six Nations medical reliance from the local hospital and doctors to those in the adjacent towns.

House calls by hospital doctors are now limited to emergencies, but the definition of the term "emergency" varies considerably at times between the physician and the patient's family, sometimes causing both parties no little annoyance. In some emergencies the hospital will send out the ambulance for the patient, but here too is another source of disparity. It is not a policy of the Indian Health Services to provide regular transportation services in the form of an equipped ambulance complete with accompanying trained medical staff. Since the cost of obtaining and maintaining such a service is prohibitive, a station wagon with a stretcher has been improvised to transport patients from their homes to the reserve hospital or to outside hospitals for referral services.

The noticeable discrepancy perceived between these emergency transportation services on the reserve and those known to be obtainable off the reserve has brought additional criticism from the people. By creating a semblance of such services the Federal Government inadvertently created certain expectations that it could not cope with financially. Thus, by accommodating its procedures to the local setting, the Government presented an unfavourable comparison in its emergency vehicle for which it was and still is censured.

In addition to the facts that physicians make few house calls and that ambulance service is not always easily available, no small part of this discord has centred on the physicians' qualifications and quality of role performance. It cannot be overstressed at this point, however, that this discord operates predominantly at a general level rather than at an entirely specific one. There is a halo of negative feeling toward all physicians that stems from, among other things, their background as "Government." To break through this barrier, a physician must become familiar to the non-conservatives through face-to-face therapeutic relationships, which are rewarding to the patient. To build the rapport necessary to foster this element of trust requires considerable time, and this time element constitutes another factor in the doctor-community relationship.

In sharp contrast to the long-term residence of Dr. Davis and to the fact that he was a local boy has been the steady coming and going of medical officers, some of whom are immigrants who have obtained their medical training in their native countries. The present physicians have had the longest tenure of all of the post-1950 doctors, but since 1950 there have been no less than twenty-nine physicians on permanent staff at the hospital, nineteen of whom have been born and trained outside Canada. This transience of physicians has been the result, particularly in the past, of the lower salaries offered by the civil service to its personnel and of the use of government hospitals by foreign-trained physicians as an intermediate step in obtaining permanent licences to practise in a province.

The fact that at least two of these physicians have been in the process of securing permanent licences is known to most Six Nations with various degrees of accuracy about the actual procedures involved. This has had a very detrimental effect on the doctor's image as a skilled specialist. Because of this belief in their lack of training, the physicians who are obtained and (or) remain at the hospital for any period of time are generally thought to be inadequately equipped to cope with the medical responsibilities of the outside medical world (i.e., non-reserve white world). The physicians are consequently dubbed "second rate," and said to be "only practising" (i.e., learning). It is further believed that they are not capable enough to be acceptable to the white Canadians and are therefore, according to the reputed evaluation of the Federal Government, "good enough" for the Indian. From this derives the not infrequently expressed belief that the physicians are using the Indian people as "guinea pigs."

Further substantiating their unfavourable judgment of the physicians' role qualifications are many factors the non-conservatives perceive in the operation of the hospital or, in other words, in the role performance of the doctors. Referral services are utilized to a great extent by the physicians, as they were by Dr. Davis in the past, but it is claimed that "if they were doing their job" this external reliance need not be so great. Since all the physicians presently on staff (and all those hired since 1950 except two certified surgeons and three in public health) are general practitioners, this dependence on outside specialists and hospital facilities is unavoidable. Even with the expanded scale of organization the hospital is still small and is not equipped with the technical machinery now available to doctors for more sensitive and extensive diagnostic and surgical procedures. As a result of the limited array of surgical equipment, for example, and the lack of certified surgeons and anaesthetists, surgery is maintained only on a very limited scale. Recent surgery has been limited to operations for hernias, obstetrics, tonsillectomies, and appendectomies, and now it is considered desirable for even these cases to be referred elsewhere.

Plate IX. Six Nations Community Hall, Agricultural Grounds, Ohsweken.

Instances in which medical advice and treatment sought off the reserve do not correspond to that previously obtained from resident physicians only serve to underscore people's assessment of the doctors as being remiss in their duties. A formal complaint was made to the Indian Health Services regarding one such case. It involved a child who, after falling down at school, experienced a great deal of pain and swelling in her leg. She was taken to a resident doctor who apparently informed the parents that there "was nothing to worry about" and advised them to put her to bed for a week and give her the prescribed pills and ointment. That same evening she was taken to a physician in one of the local towns who diagnosed her condition as blood poisoning and subsequently placed her in hospital for a week. Although this particular case could be used to illustrate other factors (including inadequate communication between physician and family, and inadequate time allowance for symptom development), it does serve to point out that different diagnoses are construed as evidence of the resident physician's failure to assess the correct nature of the illness.

Often, too, outside doctors may legitimize the patient role, or do so in a more manifest fashion (e.g., hospitalization) than do resident physicians. The resident doctors feel that unnecessary expenses should not be incurred since most of the necessary ones go unappreciated by the Six Nations. This is based on the doctor's belief that what is not paid for is not appreciated. The Six Nations strong expectation of legitimizing an illness is, of course, rooted in the practice of Dr. Davis, and a denial of this reinforcement is interpreted as lack of interest in the patient's well-being.

Here again arises the issue of the individual physician's varying diagnosis and treatment, but only the most educated realize the degree to which professional differences of opinion can exist off the reserve. In cases where the life of the patient is considered to be in jeopardy, this variation is considered critical, in essence a mistake in judgment that a physician should not be allowed to make more than once, if at all. Although it is acknowledged that "doctors are human and make mistakes," this discrepancy between ideal and real behaviour is allowed begrudgingly. The repetition of such errors, from the non-conservative point of view, serves to maintain this negative halo surrounding the doctor's image.

The ability of a physician to make immediate and correct diagnosis is of paramount importance in a doctor's role performance. The fact that the number of cases where the time required by resident physicians for diagnosis is much greater than that required by outside personnel further destroys confidence in the resident physician's ability. This problem is complicated by another factor. Most of the referral services to outside physicians are made to specialists. Hence, what may be described as a "complex" procedure by the resident physician, as occurred in one case, may be labelled "simple" by the specialist. This different rating of the difficulty of the task does not enhance respect for the resident physician. It strongly appears that this factor of specialization is seldom taken into consideration by the non-conservatives when discrediting the reserve physicians. Although more educated non-conservatives know that more comprehensive training is required to become a specialist, the resident doctors are more or less expected to be capable of equal performance.

Moreover, stories of unsatisfactory therapeutic relationships tend to further damage this relationship for both those individuals who have not yet experienced dissatisfaction and those who have. In a few instances individuals, expecting a defective result from an appeal to a physician and believing themselves competent to assess correctly the circumstances of illness, go as far as to decide on the most desirable form of diagnosis (particularly X-rays) and treatment. In 1959, a physician brought the following such incident to the attention of the Hospital Committee (*see* p. 138).

> I saw this girl two days ago in O.P. This is, again a case where the mother came into my office with ready-made orders for what the Doctor is to do. She said that she wanted to have a "check up" of her girl. I asked "what for?" and she replied "B. was in hospital." I told her that not everyone needs a re-check who have been hospitalized before. I asked if the girl had any complaints or if she observed something unusual that needed attention. The only complaint was that the girl has a poor appetite. I explained in detail what to do to make the girl eat without medications because there is no 100% safe drugs for poor appetite. I advised the mother to allow the girl to eat only at mealtimes—nothing in between meals, and not to force food into the girl because many children her age start to eat as soon as they become hungry.
>
> To complete the report it is known that B. was hospitalized because of acute cystitis, January 15-January 22, 1959. She recovered very well and on repeated laboratory examinations her urine was negative, so she was discharged after seven days of hospitalization completely healed from urinary infection. The mother was never requested to bring her child in for a re-check. Naturally, we expect everyone to report to this institution if they feel something is wrong. In this case for eighteen days the girl has been at home apparently normal and without any complaints until the mother brought her into O.P.D. with her order as mentioned before.
>
> Physical examination of the girl in hospital showed she was in good physical condition, her Hgb. was normal as well as the other tests. It was my suspicion that there was no need to repeat all those tests. It surely would have been a different matter if there were subjective or objective indications which were lacking in this case (Hospital Committee Minutes, Feb. 19, 1959).

Apprehension that all avenues might not be explored by the doctor in both diagnosis and treatment tends to produce demanding behaviour in some patients. When the expected deference and respect are not evident in the patient's attitude to the physician, the physician sometimes becomes annoyed and impatient. The attitudes ultimately brought by both parties to the therapeutic relationship are certainly not conducive to a feeling of gratification. This "clash of perspectives" in the doctor-patient relationship has been clearly explained by Friedson.

> It is my thesis that the separate worlds of experience and reference of the layman and the professional worker are always in potential conflict with each other. This seems to be inherent in the very situation of professional practice. The practitioner, looking from his professional vantage point, preserves his detachment by seeing the patient as a case to which he applies the general rules and categories learned during his protracted professional training. *The client*, being personally involved in what happens, *feels obliged to try to judge and control what is happening to him.* Since he does not have the same perspective as the practitioner, he must judge what is being done from other than a professional point of view. While both professional worker and client are theoretically in accord with the end of their relationship—solving the client's problems—the means by which this solution is to be accomplished and the definitions of the problem itself are sources of potential difference. *The very nature of professional practice seems to stimulate the patient on occasion to be especially wary and questioning.* Professional knowledge is never complete, and so diagnosis, made with the greatest of care and the best of contemporary skill, may turn out to be inappropriate for any particular case [italics are mine] (1961: 175-6).

Still another aspect of this problem is the increasing impersonalization of medical relationships. Because of the physician's working schedule, it is not always possible for an individual to see the doctor he prefers. Although "that choice of doctor business," as one Medical Superintendent referred to it, was not possible to any great extent in the past (i.e., 1927 to 1950), the fact that it is potentially possible today and yet often not obtainable is a source of minor annoyance to some non-conservatives (Voget, pers. comm., May 1966).

An additional cause of some irritation has been the problem of communication. The use of unintelligible anatomical and medical terms has been of minor concern since the doctors make special efforts to explain diagnoses and treatment in a simple fashion. Since 1950, however, English has not been the native language of many of the physicians on staff. Consequently discussions with the doctors have sometimes been hampered by a variety of accents that some of the Six Nations found difficult to understand. Although the people claim that the doctors "don't mind" repeating their advice until it is clear to the patient, this difficulty, since it hinders smooth communication between doctor and patient, can be equally frustrating to both parties. In some instances the physicians tried to increase the clarity of their instructions by increasing the volume of their voices. This problem in communication and the physician's attempts to rectify it may account for the statements made by some informants that "those doctors shout at you."

Despite the apparently intense dissatisfaction with the physicians, the non-conservatives do recognize "good" qualities of the doctors: although it is said that the physicians are "just practising" they are believed to have had a far more extensive medical schooling than their predecessors on the reserve. Comments that the doctors are "just lazy" serve well to indicate that the people separate qualifications for role encumbency from the actual quality of role performance. At the same time these non-conservative assessments highlight their belief in the physicians' lack of "other-orientedness." Although some non-conservatives still prefer to rely on medical assistance from the hospital, most state that they would prefer to consult off-reserve doctors, who in general have a higher status than resident physicians. It is important here to establish that this stated preference for non-resident physicians does not rest entirely on dissatisfaction stemming from the therapeutic relationship itself.

Related to the linguistic problem mentioned above is that of the different ethnic origins of the physicians. Because of their European and Asian cultural backgrounds and professional training, they have been looked upon as foreigners who are hence even more "outsiders" than Canadians in respect to the Indian. Among some non-conservatives there is an attitude of resentment toward these immigrants, who "come in and take over." This attitude stems from at least two sources: economic situations in which the skilled and unskilled Indians work with "new Canadians" in a competitive labour market, and the identification of these immigrants with the early settlers who are held responsible for the loss of Iroquois lands and political autonomy. The belief that these foreign-trained physicians are working on the reserve because they are unacceptable to Canadians only further adds to this resentment.

To the elite acculturated group of non-conservatives one cause for resentment has been the doctors' lack of interest and participation in the community life of the reserve. Unlike Dr. Davis, their model for comparison, only one of the present physicians has lived on the reserve and neither he nor his family has engaged in any social activities with the residents. At the time of writing no physicians reside on the reserve. Consequently the doctors' contacts with the people are strictly limited to therapeutic relationships in their occupational roles. They contribute to the community only in an economic context, and this is partly responsible for the feeling that personal profit and economic gain are their only motives for performing their duties. Comparison between the role performance of these physicians and that of Dr. Davis underscores the assumption that some doctors are not truly dedicated in a humanitarian fashion to the welfare of the people.

In the foregoing discussion many reasons for the generally unrewarding doctor-patient relationship have been presented. It is clear that non-medical as well as purely medical factors account for this dissatisfaction, emphasizing the necessity of taking into consideration the total social "field" of this dyadic relationship (Bloom 1963: 52).

It is apparent that the non-conservatives have drawn their two main components of a physician's role—medical skill and personal rapport—from two different role models. The first general attribute is derived from the personalized approach of the country doctor's role. Enactment of this role involved a continuous conveniencing of the patient by the physician with diagnosis and treatment of minor ailments usually being done in the former's home. This face-to-face confrontation resulted in exposure of the doctor to the majority of the family members not only as a professional but also as a friend. The present-day array of antibiotics was not a part of the country doctor's curative repertoire, but the personal interest was, and this is what has been retained as a vital role attribute, the means by which the humanitarian element of behaviour is manifested. As Bloom has noted: "Both the doctor and his patient may cling to images of each other that are rooted in the past, but the pressure for change is relentless" (1963:8).

The second requirement of technical skill derives from the role performance of contemporary physicians both on and off the reserve. But the advice of outside physicians has undoubtedly greater authority among the people, and is the standard against which to compare resident physicians' advice. Furthermore, there is a greater degree of tolerance of the inconveniences experienced in establishing a relationship with a family doctor off the reserve than there is when the same inconveniences are suffered from resident physicians. "Waiting and waiting" in the doctor's office before consultation and the doctor's reluctance to make house calls are taken for granted as part of this outside medical liaison.

It is evident that the non-conservatives have selectively chosen their two prime requisites for a physician's role from two different doctor models: the modern off-reserve physician and the traditional country doctor. This blend of earlier and current role components forms an ideal role picture—"the best of two medical worlds"—a combination that most Canadians would find desirable. It is in part this blend of complementing characteristics that is responsible for the discord over the resident physician's role performance. For in neither medical skill nor personal rapport do these resident physicians measure up to the ideal role. This is not to imply that a fusion of traditional and present ideals automatically brings role expectations that are impossible to fulfil. In this particular instance, however, these ideal components are not attainable in a doctor's role performance in this rural reserve area, nor in fact, in urban areas: this is the dilemma of the non-conservatives. Through the last twenty years the "personal touch" has been slowly pruned from the physician's role components by the medical profession itself, one indication of the fact that the non-conservatives are adjusting to a rapidly changing model of the physician, as well as to a changing model of medical practice in general.

With the increasing passage of time since the initiation of the hospital-centred physician, the non-conservatives have slowly altered their role expectations of physicians. Most non-conservatives now consider house calls unlikely even in "emergencies," although the physicians are still censured for their reluctance to make them. A growing realization that personalized relations are disappearing from medical practice has tended to place greater weight on the physician's demonstration of his control of medical skills and knowledge. This role component has become a dominant one and, as such, a target for much scrutiny and much criticism from the non-conservatives.

In review, it is evident that prior to 1950 the doctor-patient relationship had been a harmonious one in which the established role expectations of both patient and doctor were satisfactorily reinforced by action. The patient felt that he enjoyed a relationship with the physician that was personalized (i.e., in terms of lack of team approach, and demonstration of other-orientedness) and immediately free of direct governmental pressure for alteration. The incumbent physician was considered a member of the patient's own ethnic group, thus producing an Indian-to-Indian therapeutic confrontation.

After 1950, however, many non-medical factors began to affect this dyadic doctor-patient relationship. The largely intra-cultural role network at the local level became a predominantly inter-cultural network, and a complicated one. Within this new context the doctor-patient relationship became increasingly depersonalized with the addition of several incumbents to the office of physician, and the relationship began to deteriorate.

Also important was the Indian's attitude toward the Federal Government. Government pressure to "integrate" the Indian became very evident to the non-conservatives and touched off the characteristic apprehension about the loss of their valued status as Indians. This general pressure increased and spread for the first time in many years directly to the realm of medical services. Not only did these acculturative pressures diffuse to this area, but the persuasive and compulsive pressures, which became explicitly directed, i.e., international, planned, and far-reaching, were presented in a rapid succession of innovations. In the minds of the non-conservatives medicine and government became even more tightly entwined.

Chapter V

The Basis of Community Participation

During the 1950's and early 1960's the presentation of medical services to the Six Nations was not only governed by the federal departments and their local representatives, but also significantly influenced by the unprecedented growth of voluntary associations composed of non-conservatives. These pressure groups, often initiated by federal employees (the Indian Agent and public health personnel), were designed to improve sanitation on the reserve and to meet the more pressing problem of smoothing the discordant relations between the hospital and the community, as well as between doctor and patient.

To understand the activities of these associations and the extent of their impact on federally imposed services, it is first necessary to present the socioeconomic background of the participants and their beliefs and practices regarding health and illness, for it is on the basis of the latter that commitment to the community is derived.

It is a central thesis of this study that participation in community health associations is not entirely or even largely accountable in terms of the degree of acculturation to white society. It must be interpreted as the mirroring of the heterogeneity of the group with which the non-conservatives (and conservatives) have long been in contact.

In coping with a similar problem of the product of culture change among the Cherokee, Kupferer points out that (1963: 187),

> Implicit in most models of American Indian acculturation seems to be the assumption that "white" culture is homogeneous; therefore, as native people alter their premises, attitudes and behaviour, they' too, become like the homogeneous "white."

Kupferer found the "cultural gradient" from Indian to white inadequate to account for the differences in value systems among the Cherokee. She explains this diversity in the following way:

> The Cherokee have been encapsulated in a larger white society which has impinged upon them closely and consistently for over a century. This white society is not itself homogeneous. It is characterized by rural-urban differences as well as by social class differences. White models have included middle class school teachers, missionaries, local long time white mountain settlers as well as anthropologists. Therefore it seems a reasonable hypothesis that acculturation among the Cherokee will involve not only a shift from Indian cultural configuration to white but will also involve shifts toward differing social classes of whites. In short, Cherokee change should reflect the larger sociocultural milieu of which it is a part. We submit that it does and that an *incipient class* structure is concomitant phenomena of acculturation [italics hers] (1963: 195-96).

Kupferer's analysis of the reasons for Cherokee cultural diversity applies to the types of processes responsible for non-conservative socioeconomic variation on the Six Nations Reserve. Although it is not within the scope of this study to treat in detail the issue of an "incipient class structure" among the non-conservatives, such differentiation is evident in the status categories to be discussed below and will be seen to provide the necessary background for understanding participation in matters of health and illness at the community level.

Socioeconomic differences are obvious to the field-worker, and despite statements by informants that "we are all equal" (as is claimed by some to have been the case among their ancestors), these differences are indeed recognized by the non-conservatives on a group basis. In the recognition of these groupings, the degree of explicitness varies, however, as do the terms used to describe them. The categories are most clearly delimited by those in the higher status, particularly the elite, who are, on the whole, most conscious of their social standing and who constitute the stable leadership and membership in the voluntary organizations.

On the basis of "caring" and "contributing" (i.e., by joining and participating in the many voluntary associations, and adhering to the Protestant ethic, thereby bettering the community), the elite recognize two broad status categories. Included in those who "care" and "contribute" are the elite themselves and those remaining of higher status. Those who "don't care" or "don't care enough" and "don't contribute" are of the lower status.[1]

Within the higher status category the elite are obvious to the observer largely because of the interaction among the families in their involvement in community associations. The elite cannot be reliably distinguished from the non-elite higher status on the basis of material style of life. They are distinguishable by their continual interaction pivoting on their leadership roles in the interest groups and by their form of contribution, which ideally devalues financial remuneration as a reward for community service and usually excludes sports activities and direct participation in local government. In their strong allegiance to white middle-class values (i.e., industriousness, economic independence, education, thrift, cleanliness, tidiness, sobriety, and marital fidelity, all embodied in the Protestant ethic) they are separable from the other higher status families in degree rather than kind. The higher status as a whole is separable from the lower status by a higher standard of material wealth, by participation *per se* in community affairs, and by a stronger commitment to middle-class values.

The following schematic representation (Diagram C) of the elite's classification of the community will clarify the relationship of the analytic categories to the "home-made" categories. The elite's terms of reference have been used simply because they are one of the legitimate ways of viewing the community and because they tend to be more explicit and informative of the ethic underlying community participation. Since the total number of families in each of these categories (higher and lower status) is unknown, as is the total number of non-conservative families on the reserve, the relative size of the status group blocks is based on inference.

Diagram C

Non-Conservative Status Groups

Analytical Categories	Folk Categories
Higher Status (including elite)	Those who "care" and "contribute"
Lower Status	Those who "don't care" or "don't care enough" and "don't contribute"

The criteria used by the higher status in defining the categories are income, tenure, and type of employment, allocation of income, education, general material style of life, care and interest displayed towards the family, and participation in community activities. The criteria used by the lower status are primarily assumed wealth and authority in community life. In neither case are medical beliefs and practices of major consideration. This does not signify, however, that sustained illness that causes economic and social hardship in a family is not recognized. The consequences of legitimate illness and believed malingering are clearly perceived. Hardship resulting from legitimate (usually chronic) illness in a family is considered a handicap created by physiological and (or) social situations such as anxiety, not by the breach of social norms. According to the elite, since one "can't help" being sick, "you can't hold it against them."

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[1] *See* Appendix B for methodology

In the overall scheme of criteria ill health plays a part, but a minor one from the point of view of the elite. In cases of supposed or known feigned illness of the father and breadwinner where the mother does not "try" to seek employment when she is believed able, the status evaluation of that family is negatively affected because of the unmerited welfare allowances. Malingering does not bring the sympathy that legitimate illness deserves because one can presumably avoid it. If, on the other hand, welfare allowances are obtained through perceived legitimate illness such as physical disability or blindness, one's status is not affected to any great extent.

The fact that medical beliefs and practices are not given major importance as defining mechanisms for status categories is not an indication that these matters are *per se* insignificant. Health and methods to maintain this desirable state, however it is defined, are of universal concern to man. But among the non-conservatives they are seldom deemed direct or important causes of social differentiation. Standards of physical and mental health and the measures taken to maintain or regain health are thought to be an immediate product of the combination of such factors as level of income, allocation of income, education, style of life, and "things in life people care about." As issues related to health and medicine are seen to reflect rather than affect the general circumstances of life, their subordinate role is explainable.

A factor that must be constantly kept in mind is that, although these socioeconomic differences are indeed significant for an understanding of health practices at both the family and the community levels, they must be seen in a distinctly rural physical setting. This setting itself has no small part to play for it places greater demands on individuals, such as the elite, who attempt to emulate white middle class norms about hygiene. In the absence of a centralized water and sewage system, and with a once-a-year garbage collection, those valuing cleanliness and hygiene in the home must expend greater effort to achieve their goals than those in an urban setting who have similar values.

Higher status category

The higher status category (sample of thirty families) is defined in the following general terms: (1) regular employment of males, with many females also permanently employed, (2) occupations of the males and females ranging from unskilled to professional, (3) education ranging from grade eight to university training, (4) occupancy of houses that are owned, (5) stable family structure, (6) interest and sometimes intense involvement in community affairs, and (7) a strong future orientation.

The elite are distinguished from the non-elite higher status families primarily on the basis of their community-conscious approach to reserve life. Indeed, it is largely because of their perception of group needs and wants as well as their personal ones and because of their participation in the long-accepted white models of rural voluntary organizations that collective action, aside from local government, is sustained.

Since the type of interest and participation in the reserve community varies both within and among higher status families, this higher status category is by no means homogeneous in community commitment. The elite differ from the non-elite higher status not only in the intensity and form of their commitment but also, to varying degrees, in three other general respects. These areas are: (1) the number of children born to each family, (2) the occupations of males, and the extent of employment and type of occupation of females, and the former occupations of both males and females now retired, and (3) religion.

Of the sample[2] of eighteen elite families (including fifteen active elite and three ex-elite families) and twelve non-elite families, the total number of children born to productive couples was slightly higher among the non-elite (4.7) than among the elite (3.2). This difference within the higher status group is not so great, however, as the difference between the higher status group as a whole (3.8) and the lower status (7.6). Within the higher status, furthermore, the age ranges of children in elite and non-elite families were comparable: 11 to 56 years for the elite, and 9 to 56 years for the non-elite.

Among the elite men, a higher percentage of professionals, white collar workers, and labourers exists than among the non-elite higher status (*see* Table 4). All the professionals in both elite and non-elite are school teachers; similarly all those in white collar positions, with the exception of one elite, are involved in administration of Indian affairs. The reserve situation is true of farmers and entrepreneurs. None of the eighteen men in the elite sample falls into the latter category, whereas two or 18.1 per cent of the eleven[3] non-elite do, each owning small businesses on the reserve. The additional non-elite man, listed under "other" (9.1 per cent of the sample) was a municipal civil servant in a distant city. Among the non-elite, 45.5 per cent of the men farm, whereas only 16.7 per cent of the elite are farmers. The one unemployed elite cannot maintain a job because of ill health. Finally, in contrast to the employed elite men, of which 47.0 per cent or eight are federal civil servants, only three of the non-elite men or 27.7 per cent are federal employees.

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[2] *See* Appendix B for treatment of the higher status category as a whole.

[3] One non-elite family is represented by an unmarried woman.

Table 4

Occupation of Elite and Non-Elite Higher Status, by sex, percentages, 1966

	Employed						
	Unemployed	Professional	White Collar	Farming	Labour	Entrepreneur	Other
Men							
Elite N=18	5.6[1]	11.1	27.8	16.7	38.9	0	0
Non-Elite N=11	0	9.1	9.1	45.5	9.1	18.1	9.1
Women							
Elite N=19	21.1	63.1	0	0	10.5	5.3	0
Non-Elite N=12	66.6	8.3	8.3	0	16.6	0	0

[1] Figures rounded off to the first decimal place

A greater percentage of elite women (78.9) are permanently employed than non-elite women (33.3). Of the nineteen women in the elite category (eighteen mothers and one unmarried daughter living with her parents) fifteen work full time; of these fifteen, twelve or 80.0 per cent are federal civil servants, primarily nurses, nurses' assistants, and school teachers. Of the total of twelve women in the non-elite sample, four are permanently employed, and of these, two (50 per cent) are federal employees, one a teacher and the other a nurses' assistant. Among the elite, 63.1 per cent of the women are professionals, and 10.5 per cent are labourers, the latter being nurses' assistants at the local hospital. One elite woman, or 5.3 per cent of the sample, operates her own small business on the reserve. Among the non-elite only 8.3 per cent of the women are professionally trained, 8.3 per cent are white collar workers, and 16.6 per cent are labourers: one a nurses' assistant and one a hair stylist.

In religious affiliation the elite and non-elite difference is least marked. The most notable difference is in the higher percentage of Anglican adherents among the elite (77.7) than among the non-elite (58.3). Both elite and non-elite have the same proportion of Baptist adherents (16.6), but the non-elite have a higher percentage of United Church affiliates (25.0) than the elite (5.5).

Of these three areas—the number of children per family, the occupation of both males and females, and religion—occupation shows the most marked difference between elite and non-elite. It is on the basis of professional standing, particularly among women as well as descent from respected old families that higher status is granted to the elite.

In regard to several other factors, however, the elite and the non-elite higher status are similar: (1) a steady source of earned income; (2) careful allocation of incoming funds; (3) stable family structure; (4) a comfortable style of life made possible by well-built and repaired houses, all types of modern household equipment, and late model cars; and finally, (5) an orientation to the future. But it is the elite only who constitute an interacting social group; the other members of the higher status category do not act together according to commonly shared goals for the reserve. In their total economic background and their collective activities, the elite stand opposed to the lower status category on the socioeconomic continuum.

Although the elite are a distinct social group within the higher status category, they do share with one

MIN'S
INDIAN
CRAFT SHOP

Plate X. Mrs. Min Jamieson's craft shop, Ohsweken

other non-elite higher status group (the politicians) a desire to benefit the reserve as a whole to make it a "better" place in which to live, and a determination to maintain the reserve system and their reserve "for the Indians." However, the former goal is emphasized by the elite and necessarily implies change, whereas the latter is the most explicit aim of the politicians and stresses particularly a defence of the political status quo. This divergence in the emphasis placed by the higher status groups on the two goals is concomitant with their differing underlying values and courses of action.

There are at present two major means of improving the community. The first, whether in the area of education, health, welfare, or entertainment, is to join one or more of the many voluntary organizations long established on the reserve. The Ohsweken Agricultural Society (including the Fair Board), the Ploughmen's Association, the Ohsweken Women's Institute, the various churches and associated groups for men, women and children (i.e., women's guilds, business boards, youth groups), and to a lesser degree the Masonic Order, the Health Committee, and the Six Nations Community Project are the main associations whose leaders and members are almost entirely elite. It should be noted here that Anglican and Baptist ministers and their wives regularly participate in many of these organizations and sometimes hold office. With the exception of the last two, these organizations are local units of either nation- or province-wide associations; hence membership provides a means of gaining social prestige not only on the reserve, but beyond its boundaries, and forms a channel through which flow ideas from the larger Canadian society, as was evident in the case of the Health Committee.

Prestige is attached to office holding, but primarily the guide used to determine the degree of prestige is the evaluation of the incumbent's performance of his duties. For all members of the elite the ideals of self-sacrifice and contribution without financial reward provide the criteria for evaluation. Those who "never pitch in" on certain tasks are causes for annoyance, but at the same time when an individual being pressured into taking office becomes reluctant, this reluctance is not frowned on if he has carried responsibility in other areas or other organizations. Because of the small number of elite who consistently participate, personnel overlap in offices creates a problem in obtaining persons to fulfil needed tasks: "there are just so many nights in a week." A reluctant member, if believed the most experienced one for a particular job, is usually kidded into accepting the task or office.

The elite who most consistently take an active[4] part in the organizations, fill most of the positions of office, and make the bulk of the decisions regarding events sponsored by the associations number approximately eighteen couples and a single woman. These people are termed the "core elite," for it is on the basis of their sustained leadership that these organizations are maintained. Those in this core group interact most frequently through attendance at meetings and outside meetings by telephoning and visiting to further coordinate or complete particular tasks allotted to them for certain upcoming events. Beyond the sphere of these organizational activities, interaction is further maintained by existing kinship ties. Of the eighteen couples, only five are not immediately related to any of the remaining thirteen. Each of these thirteen couples is related to at least one other through a combination of kin ties such as sibling, parental, and affinal. At perhaps a lesser degree of intimacy, friendship and employment ties reinforce the network of relationships.

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[4] The terms "active" or "core" elite are used synonymously to indicate present involvement in community leadership roles. Ex-elite or retired elite are used interchangeably to indicate former leadership roles but present inactivity.

Slightly removed from this hub of core activity and immediate group leadership are those ex-elite who have at one time belonged to these various organizations, but for reasons other than lack of interest (i.e., ill health, old age, or additional family demands) no longer participate. There were approximately eight couples in this category at the time of field-work, though since then two older men have died. Retirement under the circumstances mentioned above does not cancel out the prestige formerly gained from such membership.

Beyond these elite, both presently active and retired, are the non-elite higher status who could be placed on a continuum of decreasing commitment to interest groups. Those who have at one time belonged to a few associations but no longer hold any interest in such activities, and those who now only sporadically participate would be placed close to the ex-elite. At the furthest boundary of the higher status would be placed those who have infrequently, if ever, established such group affiliations. The total number of this non-elite group is not known: nineteen families have been placed in this category, twelve identified through interviews and an additional seven through references from informants.

The higher status category can be viewed as a pattern of cotangential circles radiating out from below the core elite group. Each circle is attached to the top of the elite circle because these families manifest the same material style of life and future orientation, but each extends below the core elite group because of their decreasing affiliation to interest groups.

The second socially accepted method of contributing to the community is to enter local politics and become one of the twelve Councillors or the Chief Councillor. Three of the elite have, at one time in the recent past, become candidates for the office of Councillor. One ran for election shortly after the elective system was established and held office for a few years. This individual again ran for office in the late 1950's with another elite. Although each agreed to withdraw his name, confusion resulted over the final decision as to who was to take the action. Each thought the other had withdrawn, and the result of their joint candidacy was the success of a third, non-elite, candidate. The third elite, successful in a later election, is the only contemporary example of overlap between the elite and the Council. This overlap, however, lasted for only a single term of office (two years) and occured prior to this individual's involvement in one of the sanitation committees. This individual's influence in Council was not far-reaching and consequently did not serve to later affect the Council's decisions regarding the acceptance of certain innovations. Moreover, the zeal once demonstrated by this committee was waning: this tended to lessen the drive for change, and the necessity to appeal to Council for its approval.

But becoming a politician and participating in the voluntary organizations are two almost mutually exclusive methods of contributing to the community, and hence different ways of gaining social recognition. Membership in these voluntary associations can be a lifelong commitment if one chooses (as most of the core elite have done) but, except for a few Councillors, the local politicians have not taken this approach. The elite, furthermore, tend to have a more extensive education and to be more oriented to the surrounding white culture, whereas the politicians, who are more oriented to maintaining the status quo, have generally received less formal schooling. Those who choose one of these channels of contribution and personal reward seldom participate in the other. Furthermore, some of the politicians have a non-elite higher status background, and in a few cases a lower status background, whereas the elite, by definition, are entirely of higher status.

Local politics appears to provide one channel of social mobility within the reserve; beyond the reserve, formal education and, in the past, the Mohawk Institute training provided other means. Recruitment for the elite, however, tends to come predominantly from the closed ranks of pre-existing elite families. Of the eighteen core elite couples the parents of either the husband or wife of twelve couples were active in leadership roles in the many associations for several years. Of the remaining six couples, four have been recruited from those who have transferred similar activities they had established during residence off the reserve to those existing on the reserve, and two have lived on the reserve but developed an interest in community programs. In the latter instance the wives are the source of motivation for participating, but in only one case do the husband's activities approximate those of his wife. The other husband is said to "drink a lot" and to demonstrate no interest in community activities. Since many children of the core elite leave the reserve for higher education and permanent employment, the problem of recruitment in the future may ultimately force these now relatively closed ranks to open to non-elite children. Presently, the core elite rank is closed both within and without—from within in that persons who do not live according to the Protestant ethic are not generally accepted, and from without because of the apparently limited aspirations of either non-elite higher status or lower status to join the associations.

When their respective community goals make it necessary for the politicians and the elite to work together, they do not generally find cooperation easy to establish. Despite clashes between the two groups, cooperation and receptiveness to ideas must be practised in many ventures, particularly where monies are involved. Frequently the elite must make financial requests of the politicians and therefore cooperate with the Council, but where money is not involved they prefer to operate autonomously.

Nor do these two non-conservative groups (i.e., the politicians and the elite) individually or together have any significant established relationships with the conservatives regarding the reserve community. The elite, for example, hire a professional Indian troupe at the time of the Fall

Fair to bestow an Indian name on an approved individual, and one or two Longhouse adherents usually run for office on the Council, but there is no formal or informal arrangement among the community-minded conservatives and non-conservatives for getting together for the benefit of the whole community. As politicians, however, the Councillors cannot exclude Longhouse interests because "after all, they are our people." The conservatives, meanwhile, are consistently counselled by their preachers not to join in extra-Longhouse activities, either politics or interest groups (Shimony 1961: 131). In practice this separation of conservative and non-conservative into their respectively defined "communities" is manifested in the absence of Longhouse people from the voluntary organizations and the non-conservatives' general lack of knowledge of the conservative way of life. The conservatives are seldom enjoined to become members of interest groups, partly because of their lack of response to past invitations. But if they do join they are treated as any other member and are often encouraged to take office. The sporadic meetings of the Mohawk Workers do join, though only temporarily, some conservatives and non-conservatives. These occasions, which are sparked by some threat to the status quo, do not serve as permanent group adhesions to the community structure. None of the elite are active "real" Mohawk Workers.

In the rest of this chapter, although references will be made to the non-elite higher status, the characteristics of the elite proper (i.e., core elite and ex-elite) will dominate the presentation. This emphasis is not undeserved given the role of the elite in community health programs. It will later become evident that the existence of these two modes of community contribution, that is the politicians (representing the non-elite higher status) and the elite, plays a decisive role in the type of medical and health innovations introduced to the reserve, and in their reception.

The core elite is comprised of eighteen couples and a single woman. With the exception of "down below," their houses, as well as those of the ex-elite, are scattered throughout the northern half of the reserve and are not clustered in one particular area. The homes of the non-elite are found throughout the reserve, with the exception again of the northeastern "down below" area.

Most of the core elite, though ranging in age from 37 to 86 years, are in the grandparental generation, and their offspring are the source of new recruits, some of whom have been longstanding members of the many interest groups. Despite the generational difference in age, social cleavages within the group along age lines are not evident.

Among the non-conservatives, the style of life of the elite tends to be consistently the most elaborate. They live in a moderate and very comfortable fashion, maintained by steady incomes that are carefully distributed: necessities first, desires second. Monies needed for such things as food, clothing, and school equipment are never lacking because of expenditures on intoxicants, betting on horse races, or playing bingo.

With very few exceptions both men and women earn salaries through jobs they have held for many years. Many are employed on the reserve itself, and including those working off the reserve many are federal civil servants. Of the total of thirty-one core elite men and women on the reserve who are permanently employed or have been so employed (one man and five women are not working, nor have they ever worked) twenty-two, or 70.96 per cent, are employed on the reserve (*see* Table 5). Twenty individuals, or 64.51 per cent, are federal civil servants. Of the seventeen men who are or have been permanently employed, three are now retired from civil service positions. Of the fourteen women who have been employed or are presently working full time, one has retired from school teaching, and the other two stopped teaching before having their children. One of these resumed teaching on a full-scale basis when her children were grown, but terminated work prior to retirement age. All the core elite who are teachers (nine: two men and seven women) work on the reserve.

Table 5

Location and Type of Employment of the Core Elite, 1966

	Men	Women	Total
Total employed	N=17	N=14	N=31
Permanently unemployed	1	5	6
Presently employed	14	11	25
Retired	3	3	6
Employed on reserve	9	13	22
Employed off reserve	8	1	9
Civil servants	8	12	20
Not civil servants	9	2	11

Within the civil service elite, occupations range from the unskilled labour bracket of maintenance men in the public schools to the professionals, mostly women, in the schools and hospitals. Table 6 details the jobs held in the federal service.

Table 6

Core Elite Jobs in the Federal Civil Service, 1966

Jobs	Men	Women
Total	N=8	N=12
Teacher	2	7
Nurse	0	3
Nurses' assistant	0	2
Clerk	3	0
Maintenance	3	0

Of about 120 full-time federal jobs available—10 in the combined Indian office, 55 in the reserve schools, and 55 in the hospital—16.66 per cent are occupied by the core elite.

Of the total of eleven men and women not employed by the federal service, only one individual holds a professional job. One of the two women in this category is self-employed on the reserve, and the other is a nurse in a nearby hospital off the reserve. Of the nine men, one is a clerk in the Council House, and eight are semi-skilled and skilled workers. Six of these eight commute daily to their jobs in industries off the reserve. Three of these nine men had been full-time farmers until a few years ago, when they sought permanent employment to procure larger incomes. It is notable that with the exception of a few ex-farmers and the one woman, the core elite are not independent entrepreneurs. The majority of local enterprises are grocery outlets that are financed and operated largely by the more "well off" lower status persons and a few non-elite higher status families.

Incomes of the core elite based on the earnings of the adult male member of the family at the time of fieldwork ranged from approximately $3,000 to $13,000 a year. Total family incomes, however, are usually larger because of the wife's permanent employment, and these accumulated resources would reach an estimated $20,000 at the highest point. It should be noted, however, that the majority of elite women do not work permanently outside the home when their children are young. When their offspring become teenagers, employment is usually sought both for interest and additional income.

Incoming monies are handled with care and forethought. Savings accounts are used, as are other methods of investment such as savings bonds, but purchasing of stocks appears to be rare. Guarantees against financial drains brought about by sickness, fire, or accident are commonly made by purchasing various types of insurance for home and farm. Although some make outright purchases, buying on time is a common method of purchasing costly items such as televisions, "hi-fis," cars, farming equipment, and furniture. These families are extremely proud of their good credit ratings in the local towns and cities, and highly value economic independence of the nuclear family.

Although most families have at some time stringently budgeted, this pattern is generally continued in a more relaxed fashion in later married life as expenses of daily living become familiar, and (or) income increases. On reduction of income, such as during retirement or misfortune, however, they return to careful budgeting. Although the father is acknowledged as the prime authority figure in the family, the women are often the budget keepers; this varies greatly among families, however. Children are usually given a weekly allowance and "taught to live within their limits," or ideally so, but they are seldom denied toys or more expensive items such as guitars and radios, if the income permits and if they show a persistent desire for these things.

In addition to covering the daily expenses of food, clothing, and house maintenance, the incomes of these families are put into the houses they own and, in most cases, have built or internally modified themselves. Part-time farming activities also create a demand on income (and contribute to it in some cases) for machinery, seed, cattle, and buildings. Pride in the quality of their homes, the contents, and surroundings is very noticeable both to the outsider and to the other members of the elite. Some split-level homes that have been built recently are pointed out to the observer as evidence of the personal endeavour of the residents. Both bungalows and older two-storey brick and wood structures are common among the elite. Generally distinguishing the elite from other categories on the reserve is the state of repair of their homes. With few exceptions houses are externally painted, kept in very good repair, have screened windows, and are surrounded by carefully kept lawns with flowers and often vegetable gardens. The yards are free from debris, unlike some of the lower status homes. Outside privies are rare, having been replaced within the last ten or fifteen years with bathrooms fully outfitted with hot and cold running water. Garages, too, are common additions to the elite homes and with few exceptions they contain new cars.

The interiors of the elite houses are well kept and fully furnished with an eye to taste and the family budget. The women are interested in decorating ideas, and although most do not buy the popular monthly magazines devoted to interior decorating, they do follow the trends in daily newspapers and in the other women's magazines that they subscribe to or regularly buy. Certain homes mentioned to the outsider for special attention are inevitably ones that have been panelled or altered in some fashion by the owners. Hence personal ingenuity involving both taste and work are prized above the sheer display of wealth. Most of these homes have a full complement of modern appliances and luxuries such as electric stoves (some stoves are gas, as are the furnaces and room heaters), refrigerators, freezers, televisions,"hi-fis,"electric coffee makers, frying pans, toasters, and, more recently, women's hair dryers. Because of the scarcity of water, automatic washing machines are less evident, but dryers are common.

Among the elite women, the role of homemaker, despite the prevalence of permanent employment, is a very important one. The tendency of the Women's Institutes and Ladies' Guilds at the churches to emphasize this role in its modern context brings comments from the older women on how "things have changed" since they raised their families "the hard way" (i.e., churning butter, baking bread, milking cows).

Pride is taken in personal and household cleanliness and tidiness, in food preparation and preservation. If one is a "good housekeeper," she is neat about her own appearance and that of her family, she takes pains in meal preparation to ensure a proper diet, has a clean house which is tidy most of the time, and is generally thought to go beyond the call of duty in all her household tasks, particularly cleaning in places that "people don't see." Some of these women freeze produce from their own gardens and still make preserves and baked goods to show at the Fall Fair. Those who win prizes for canning, baking, or sewing are well known among the elite, and particular enjoyment is gained from competing with relatives and friends.

Being very conscious of diet, the elite women make purposeful attempts to produce well-balanced meals for both nutritional value and caloric value for those with weight problems. Vegetables, both fresh from the garden and canned or frozen, are always an evening meal component with meat and potatoes. Salads are very common all year round, as is the use of milk for children; in the summer, "pop" and Freshie are only snack drinks, unlike the lower status practices.

Desserts are generally a regular supper-time treat often baked or made by the women, although the baker does supply some of them. Meat, with heavy emphasis on roasts and beef products, is generally baked, in contrast to the lower-status frying practices. Because many elite women are daily away at work, however, foods are more frequently fried than is desired by them. Young girls are initiated in cooking and baking at various ages, usually starting at seven or eight by making "pies" out of their mother's left-over pie dough. They are told the "do's and "don'ts" of cooking, and the short cuts; to this basis is added the formal home economics training received in both public and high schools.

Considerable thought is given to food purchasing, both in the items to be obtained and the prices; all elite women have an eye for bargains. Much of this type of shopping, as for other things, is done in the local towns, particularly Brantford. In contrast to the elite, many lower status families use the general stores on the reserve, usually because credit is given to residents.

Sewing and knitting are either learned from relatives or self-taught. Girls will frequently make some clothes for themselves when they are in their teens and, depending on their skill and clothing desires, may or may not continue this practice in their adult years.

The household composition of the elite, with few exceptions, includes only the nuclear family. Whereas the grandparental generation elite had up to seven children, the present generation have on the average from one to five children, with 3.2 being the average number born per family. A strong part of the core elite's outlook on life is planning for the future with the available resources, and family planning is very much a part of this future orientation. As a result of successful birth control procedures and the financial ability to enlarge the house if necessary, the elite houses are not overcrowded, in contrast to the lower status houses.

The structure of the elite family is very stable, based on legal marital unions and a strong Christian scorn for infidelity. When extramarital affairs do occur in the community they produce considerable local interest and comment, as do premarital affairs and pregnancies. This concern is based on the strong conviction that a girl "should have some kind of training" toward a livelihood despite the eventual termination of work due to marriage and motherhood. Not only the lack of education as an experience in assuming responsibility of major importance, but the youth of the mothers is a concern: "She is so young, how can she be a good mother." "Young people shouldn't get married so young; it takes time to understand children." This concern also arises from the fact that the elite women place great weight on the role of the mother as being something more than the result of a biological incident, a role they believe can be better performed by adults than by teenagers. It is because of this approach to the role of motherhood that the high frequency[5] of illegitimacy on the reserve is disturbing to the elite. Although information on illegitimacy and those who "had to get married" was not easily obtainable, it appears from the data that illegitimate births occur less frequently among the elite than among the lower status category.

Children are a very positive and frequently planned-for aspect of elite family life. Children are desired, loved, carefully taught, over-indulged, doted on, and assisted in educational pursuits toward the goals they themselves choose. The parents, not the older siblings, are the dominant socializers, and commonly the father, unlike the lower status father, plays an active role in child raising. Ideally, the parents take a single stand on disciplinary measures, and these measures, although not always agreed upon by both mother and father, are usually given verbally, noticeably without the shouting that frequently occurs in similar situations among the lower status families. Reasons are generally given with proper reprimands or requests for good behaviour when the child is old enough to understand them, but all parents resort to "because I say so" at times when reasons are not easily phrased. Older children are generally not allowed to punish their younger siblings unless there is a great age difference, and even then thought is given to the rightness of the action.

The elite mothers are concerned about the "best" methods of child raising. They discuss various approaches observed in their community and read about in popular magazines and follow with deep interest the physical and social development of their children. Infants tend to be given solid foods, for example, earlier than among the lower status families; they are toilet-trained earlier and weaned earlier. Bed wetting and the late development of speaking and walking are of more immediate concern to the elite mother than to other mothers. They usually seek advice at these times from their own mothers, their friends, or outside authorities such as nurses or doctors. Since some elite women are themselves nurses this advice can often be gained from familiar persons such as friends or relatives, rather than from the hospital, where the more formalized relationship exists between nurse and inquirer. Orthodontists' services, for example, are utilized more by the elite when the need or want is demonstrated than by those of the lower status, who have neither the funds nor the inclination for such "extras." Unlike the middle class white mother, however, these young women are not devoted to the Dr. Spock "bible" (1962). They turn to personal sources of information in the main, although many read the Federal Government publication *Canadian Mother and Child* when their first child is born.

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[5] In 1961, 26 per cent of the infants born in the hospital were illegitimate; in 1964 and 1965, the figures were 25 and 27 per cent.

Elite parents encourage a good school performance in their children, and follow their scholastic achievements or lack of them with definite pride or discouragement. Respect for authority, which early in a child's social experiences is personified by the Sunday school teacher, minister, and school teacher, is insisted upon, unlike the practice of lower status parents. Children are urged to complete high school and take some kind of higher education along either technical or academic lines, as most of the parents have done. Parents, however, do not promote specific occupational undertakings for their children, nor do they stress the professions, although more elite children are now entering hospitals, teacher's colleges, and universities. Parents demonstrate a quiet but definite pride in their children's occupational successes and their promotions, which are frequently mentioned to friends and relatives. Resourcefulness, hard work, achievement gained by self-sacrifice, and persistence are highly valued in both sexes among the elite, and individuals who "have made it the hard way" (i.e., without parental encouragement, financial or otherwise) are particularly respected, especially if that individual has turned his abilities to "contributing" to the community, not only to himself and his "own pocket."

Entertainment among the elite is usually enjoyed in the company of relatives primarily and friends secondarily. The nuclear family is also the play unit; family outings include picnics, shopping, going to a show, the Fall Fair, and the Toronto Exhibition. Vacations, which are commonly taken by the whole family, often involve car trips throughout Canada and the United States. Formal family reunions uniting bilateral kinsmen sometimes are held every few years. Others are less formal reunions than get-togethers, often spurred on by occasions such as birthdays, anniversaries, or holidays. Unlike the lower status individuals, the elite do not participate in bingo games. Parties held by a couple for their friends are very rare, with the exception of showers for prospective brides. Dinner parties for nonkinsmen are almost nonexistent, but there are supper get-togethers among relatives, and among members of the churches and organizations at regularly scheduled times in the summer and winter. The most common form of partying among the younger elite is going outside the reserve to a legion hall or an armed forces club. Five of the eighteen core elite couples are Baptist, and of these adults, possibly only one man will drink on occasion and then especially at Fall Fair time. The remaining couples in the elite, with one exception, are all Anglican, and these will "take a drink." But almost without exception, excessive use of alcohol is not seen among the elite. Such indulgence is severely frowned upon and is often the reason men are excluded from the in-group though their wives would be considered potential members. Drinking tends to be reserved for special social occasions and commonly takes place outside the home, although seldom in the local taverns where lower status persons are frequently found.

Men and women participate in different types of entertainment; men attend the lacrosse, hockey, and baseball games, and the women engage in guilds associated with the church and in art classes recently started on the reserve.

Although not recreational, a form of entertainment is supplied by the various interest group meetings and the social functions held throughout the year. Church and Fair Board picnics and suppers, for instance, take place annually, and each family attending contributes some baked foods.

Although these organizations do constitute entertainment, they are action-oriented groups designed to fulfil certain functions in the community. Meetings, usually monthly, are regularly attended by the elite and are important and enjoyable events in their lives. Often strong differences of opinion on the course of action to be taken provide topics of local conversation for some time afterwards, and of no little concern is the manner in which the meeting itself was conducted. The elite have very definite ideas on how a meeting should be carried out. The dominant idea is that the business section should be carried forth quickly, that ideas for action should be presented clearly, and that after adequate time for discussion without side issues being dominant, a resolution should be presented and voted upon. Those individuals who dominate the discussion with their personal grievances or are aggressive in their interactions are a constant source of annoyance and gossip, particularly if they break a tacit understanding that grievances against the white man are not to be aired in these meetings. As in any meeting of this kind there are "movers," those who bring items on the agenda to a head, and those who "talk around the issue" and "never get anywhere." It is this ideal of proceeding quickly but carefully through the agenda that dominates the elite's pattern of meetings. It is also undoubtedly the Council's practice of sometimes belabouring issues, as they see it, which causes the elite to disdain its political proceedings, as well as their own committee meetings.[6] Frustration has come to

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[6] The politicians equally adhere to the norm of congenial interpersonal relations in their meetings. Aggressive behaviour by any Councillor or person bringing issues to the Council's attention brings remarks from the politicians of disapproval. "You've got to be diplomatic, you can't shout at people." The "clashes" between elite and Council on sanitation issues as well as others have been thus termed by both elite and politician because of the nature of the aggressive interpersonal relations that arise when the issue raised has not gained acceptance by both parties.

Plate XI. "Chiefswood," the home of Pauline Johnson (1861-1913), the Mohawk poet. Renovated by the Six Nations Council and opened to the public in 1963. (Courtesy Royce Phillips, Brantford, 1963).

many elite who did try to introduce more orderly methods of business into local politics. The principle of organization, itself, is a dominant characteristic of elite collective life.

The elite, in summary, differ from the remaining higher status individuals in the emphasis they place on an altruistic community contribution. They, like the politicians in particular, hold grievances about past injustices, but unlike the others (especially Mohawk Workers) they do not establish this attitude as a focal point around which their community activities pivot. Furthermore, in their positions as teachers, nurses, clerks in the Indian administration, and maintenance men in the public schools on the reserve, issues such as sanitation are constantly brought to the fore in their daily lives. It is undoubtedly their perspective of the community through their occupational roles that is in part responsible for their participation in sanitation innovations.

Medical beliefs and practices

The higher status are clearly the most health-conscious of the two non-conservative status groups. Health is believed to be the regular, normal state of an individual, the expected state, and ill health the abnormal one. But health, although thought of as normal, is not an inherent or natural state of the body and mind. It is a condition for which the individual adult and (or) parent is responsible. It depends upon thought and action, essentially care: "You have to take care of yourself." Ill health, furthermore, is expected to come with old age as the lower status believe but its severity is thought to be possibly reduced by taking "proper care of yourself when you are young."

This "taking care" of oneself and one's children is another way of saying that preventive measures are part of good health. That they do engage in such measures is evident in their concern with a good diet, regularity of meals, sanitation in the home, rest and exercise, dental care, and the use of vitamin pills and cod liver oil for the children. In contrast to the practice of some of the lower status, preventive procedures, not limited to the realm of pharmacopoeia, permeate many aspects of daily living. Higher status mothers (especially the elite) are more knowledgeable about the different diseases against which their children are immunized. They also tend to contact a physician soon after they believe they are pregnant to ward off any complications or discomfort that might be avoided, in contrast to the majority of women on the reserve, who consult physicians at the prenatal clinics for the first time during or after the fifth month.

Table 7

Prenatal Clinic Attendance for 1961[1]

Month of pregnancy at first visit	Number of mothers attending	Per cent of total mothers attending
2	2	1.6
3	11	9.0
4	11	9.0
5	21	17.2
6	20	16.4
7	14	11.5
8	14	11.5
9	12	9.8
Total	**105[2]**	**86.0**

[1] Figures were compiled by Public Health personnel for their own use.

[2] In 1961 there were 122 women admitted for delivery and of these, 17 or 13.9 per cent, had received no prenatal care prior to delivery.

Disease causation, for the higher status adult, falls into the realm of physiology and of the natural and social environments of the individual. Adults talk in terms of "viruses," and "germs" in relation to such illnesses as diarrhoea, childhood diseases, influenza, tuberculosis, pneumonia, and upper respiratory infections, but not in relation to cancer, diabetes, and arthritis. These last three diseases, along with heart ailments, are generally thought of as degenerative diseases; they are not labelled as such, however, as there are well known instances of these illnesses in middle-aged persons.

The higher status parents, concerned about contagion of communicable diseases, teach their children certain habits that might decrease the possibility of their contracting illness (e.g., "I always taught my children never to drink out of somebody else's glass or bite off their apple."). Although the stresses and strains of modern life are particularly noticeable to the older generation (as one informant commented "everyone's in a hurry these days"), higher status adults are aware that psychosomatic factors can be associated with such illnesses as recurrent headaches and stomach ulcers.

Mental illness, often referred to as not being "right mentally" and infrequently as "crazy" or "nuts," is seldom talked about, but is usually credited initially to social circumstances such as "his upbringing" or her "being pushed too far in school" (i.e., too many demands made on the child). In cases where children and adults are known to have been abnormal since birth, the defect is assumed by the more sophisticated elite to be either inherited or congenital. In general, the causative factors of emotional disturbances and mental retardation lie in the area of the unknown and are a subject of speculation. When causes are stated, they frequently involve numerous interacting forces, such as the physical well-being of the mother during pregnancy, the conditions of delivery, and the prenatal care and concern accorded the child as he is growing up. Moral transgressions, however, are not a part of this speculation. The general attitude toward persons considered to be abnormal is one of tolerance, based on the belief that "they can't help what they are," and parents who have given care and devotion to children are respected and commended.

When physical illness does occur, this "taking care" attitude is manifested in attempts to cope with minor ailments in the home environment independently of consultation with a physician. This home "doctoring" is aided by past experience of handling similar illnesses, by consulting relatives, by referring to some literature in the home, or by remembering some information gleaned from past reading. Only when these efforts have not brought relief from the condition is a doctor consulted.

There is apparent a definite reluctance "to run to the hospital with every ache and pain," and an implicit belief that most ailments are minor and will eventually "clear up" of their own accord. As one mother stated, "I took them [children] to the doctor only when their temperature wouldn't go down." This reluctance to seek professional aid is also dependent upon the belief, particularly related to childhood diseases, that there is little that physicians can do to foreshorten the course of the sickness. In one such case a mother who knew that her children had been in contact with others with chicken pox consulted a friend, who was also a nurse, when her child broke out in blisters. After inquiring about the kind of care that should be given, she phoned a public health nurse regarding the "incubation period" and put the child to bed. She had not consulted a physician because "there is no medication to speak of. You just have to keep them quiet and give them lots to drink."

Higher status parents, on the whole, are much better prepared to cope with illness than lower status adults. Not only do they have a higher education (particularly the elite) and realize the seriousness of certain diseases (i.e., diarrhoea in infants), but they usually have literature in their homes to consult and well-stocked medicine chests. Unlike the lower status homes, for example, a thermometer is a common household item and is regularly used during illness to provide tangible evidence of fever. Medicine cabinets are well supplied with modern headache remedies (222's, Bufferin, Aspirin and Anacin); antacids for stomach complaints (Alka-Seltzer, Bromo-Seltzer); laxatives (Milk of Magnesia, Eno, and Cascara for children); cough medicines (Pertussin, Jack and Jill); mentholated rubs (Vicks and Mentholatum); liniments (Heet, Oil of Wintergreen, Absorbine Junior); disinfectants (iodine, mercurochrome); lotions for insect bites (Calomine); and especially in the summer, patent medicines for diarrhoea, such as Wild Strawberry and Kaopectate . In addition are kept band-aids, gauze rolls, and adhesive tape. Hot water bottles and heating pads are also used to relieve muscular pain and ear-aches.

The higher status adults rarely use Indian medicine in home care. Some of the grandparental generation, remembering their parents' using Indian remedies such as catnip for fever in children, plantain poultices for cuts and scrapes, and touch-me-not[7] for poison ivy, have used these on their own children and sometimes on their grandchildren. The present parental generation has not continued this practice to any significant extent. One informant, for example, who is a part-time farmer, uses an Indian remedy to reduce bloat in his calves, and he and his wife occasionally take "red whip"[8] as a spring tonic. One woman, after repeated attempts to find medical treatment to remove a rash caused by detergents, resorted to an Indian remedy suggested by her father-in-law. The remedy was successful in alleviating the condition, and she has subsequently declared in a local newspaper her intention to study the efficacy of herbal remedies at university. Another higher status man, after experiencing severe nausea from radium treatments for cancer, acquired "cancer medicine" from a Longhouse Chief. Although this individual was not contacted personally during his period of illness, it is claimed by some that "he lived longer because of it," and by others that "it might have helped."

Those of higher status, generally speaking, regard Indian medicine as somewhat of a novelty that might prove efficacious in some cases and use it occasionally, almost entirely in instances of minor ailments or as a last resort. With the exception of those few who "believe in it," the general attitude is one of blanket scepticism unless a specific herbal remedy has proved effective in a known case; and then only this particular remedy is granted efficacy. As one older informant phrased it: "I won't say it all works, but some of it does, because I tried it." In this instance he was referring to his discomfort from haemorrhoids, which was removed by drinking "a pail of liquid an old Longhouse man gave me."

Despite the present utilitarian insignificance of Indian medicine, the elite take a very definite pride in Indian remedies based largely on the fact that the components of some modern drugs include herbs utilized and found to be effective by their ancestors. There is, in addition to this pride, a curiosity about whether these remedies "really work." But, as most of the elite claim, this can seldom be established because modern drugs are usually taken at the same time as herbal concoctions.

Finally, home remedies, such as mustard plasters for colds, and onions and brown sugar or molasses for coughs and sore throats, although once used by the grandparental generation, are rarely used by the present parental generation.

Contact with physicians, as mentioned previously, is prompted by the persistence of the symptoms that cause considerable concern. It is probably because of this desire to terminate the debility that the physician's orders are usually acted upon immediately and consistently. Medication, taken or given regularly according to directions, tends to be continued sometimes after the symptoms have subsided.

The higher status attitude toward the doctor (despite the "doctor trouble") is one of respect for his academic achievements and technical skill (as well as for the income he is able to demand) and usually encourages compliance with his recommendations. There is, however, a tendency to adhere to the regimen more strictly, the more severe and discomforting the illness. The higher status desire to be as self-sufficient as possible during illness, a characteristic that tends to make them more desirable in-patients than the lower status adults. Admission to hospital is not considered a pleasurable experience, but unlike the higher status women, those in the lower status category do remain in the hospital for the eight-day recovery period following delivery.

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[7] *Impatiens capensis* and *I. pallida* are common species found in southern Ontario (Montgomery 1962: 87).

[8] "Red whip" is described by those who know of it as a "willow bush" whose bark takes on a reddish cast in the spring. The botanical designations of this bush are unknown to the writer.

The sick role is not cherished as an opportunity for relief from labour. The role itself is gained only by legitimate illness, and when such is manifested in children great care is given them for the duration of the illness. They are exempt from household chores and catered to, within limits, in their tastes in food and entertainment although, unlike the permissiveness allowed the lower status children, they are usually confined to their regimen. Feigned illness is soon recognized by the observant parent and not allowed to be an excuse for missing school.

A sick person, by their definition, is one who is confined to bed, usually with an acute form of illness. When a person is "up and around" the house, although he is no longer considered sick, he is still recuperating, and many restrictions still apply to his behaviour. As with the lower status adults, full activity of the individual is the main criterion for defining good health. If ordinary daily activities are restricted due to ill health, the person is not referred to as "sickly" but as "delicate" and "not too well." If this (usually chronic) condition in an individual results in his reneging on simple tasks, particularly among the elite in their voluntary associations, the group as a whole does not respond with sympathy, especially when the tasks are not demanding. But in instances where an individual is known to suffer pain from a debility (e.g. arthritis) and bears the discomfort stoically he is the object of sympathy and admiration.

Health, finally, is considered a very positive state. It is the normal, desirable state of being, but one that has to be programmed daily with forethought and sustained action. A healthy person is one who can maintain his regular daily activities of both work and pleasure without restrictions of diet and exercise and without the need for medication. He is a person with a sound emotional balance and an alert mind, one who can cope with the "ups and downs" of life and "still keep going." Health is more than the sheer absence of debility and more than an interlude between recurring debilities. It is perceived as almost a steady state characterized by stamina, resistance, and resilience.

In conclusion, it can be seen that the future orientation of the higher status individuals is demonstrated in many ways in their medical beliefs and practices. Their concern with eliminating sickness appears in their preventive measures, which, unlike some of the lower status habits, are not restricted to pharmacopoeia but extend to many facets of their lives. The precautions are taken by the adults regularly and before symptoms have developed to reinforce the need of such measures. Their concern for the "after-effects" of disease further manifests their future orientation, particularly as it applies to the childhood diseases experienced by their children. Measles and chicken pox are of the greatest importance to the mothers, who are apprehensive about possible defective vision and scars resulting from these illnesses.

The future orientation involving preventive measures, which extend beyond the simple immunization and vitamin-taking stage, necessarily produces, or is a product of, the independence of the higher status family. Action *is* taken by the family in the home without the prodding of medical specialists; a fact that, according to Firth (1959: 162), provides the most sensitive indicator of the acceptance of introduced medical beliefs. It is because these measures, as one elite woman phrased it, "are common sense" to them that they find it difficult to account for the behaviour of those of lower status who take few precautions against ill health and, as she and many others claim, come to the hospital "for the least little thing" (*see* p. 135).

The greater self-reliance of the higher status, strongly a combined product of economic factors and attitude, is reflected in the source from which premiums for hospital insurance are paid. Whereas 20.0 per cent of the higher status families are insured by the Indian Agency's group plan, 64.3 per cent of the lower status are covered in this fashion (*see* Table 8). In contrast to the 76.7 per cent of the higher status families who are insured through either their employer (63.3 per cent) or direct payments to the Hospital Commission (13.3 per cent), 28.6 per cent of the lower status families (21.4 per cent through employers and 7.1 per cent through direct self-payment) are similarly insured. The Veterans Affairs Department assumes responsibility for one man in each of the higher and lower status categories, and the wives in both cases are insured through provincial welfare benefits, one because of age and the other because of physical disability.

The core elite have an even greater rate of self-support. Of the sample of eighteen families (fifteen interviewed and three known through records), seventeen families, or 94.4 per cent, are responsible for their

Table 8

Status Groups and Source of Payment of Hospital Insurance Premiums, 1966

Status Group	Sample (Families)	Agency		Veteran[1]		Pay Direct		Employer	
		N	%	N	%	N	%	N	%
Higher	30[2]	6	20.0	1	3.3	4	13.3	19	63.3
Lower	14	9	64.3	1	7.1	1	7.1	3	21.4
Further Breakdown									
Core Elite[3]	18	1	5.6	0	0	1	5.6	16	88.9
Non-Elite[4]	12	4	33.3	1	8.3	2	16.7	5	41.7
Politicians	18	9	50.0	2	11.1	3	16.7	4	22.2

[1] Department of Veterans Affairs

[2] This sample represents the number of families interviewed. The fourteen lower status families in this sample are those described in the methodology appendix.

[3] The sample for the core elite is composed of the fifteen families interviewed and the three known through record materials.

[4] The sample for the non-elite higher status is derived from those families interviewed. Since four of the twelve families have a politician husband or wife, there is overlap of families in the samples of non-elite higher status and politicians. Between the core elite and the politicians there is only one family common to both categories.

own premium payments (88.9 per cent pay through their employer and 5.6 per cent or one family pays directly). Only one family is insured through the Agency.

The politicians (sample of eighteen represents the most recent incumbents of office), in contrast to the elite, were found to rely more upon Agency coverage. Half of the families in this sample were insured by the Agency, and 38.9 per cent were responsible for their own payments (16.7 per cent by self-payment, and 22.2 per cent through their source of employment). The results from the non-elite higher status sample, in which there was an overlap of four families with the politicians, were found to lie mid-range between the core elite and the politicians.

The differing economic positions of the politicians and the elite are reflected in these figures. The high percentage of families insured by the Indian Agency does not indicate that these families are classified as indigent (i.e., not normally self-supporting). A few of these families feel that it is the Federal Government's responsibility to meet the costs of medical care, but most of them tend to live on incomes that are lower than those of the elite. The fact that some of the politicians are of retirement age is not in itself a reason for the high percentage of Agency coverage. An almost equal percentage of the elite (23.7 in comparison to 27.7 of the politicians) are retired, but they exist on pensions from their former source of employment, predominantly the federal civil service.

That the elite are separated from the non-elite higher status group by more than economic factors, namely their attitudes towards self-reliance regarding medical matters, will become evident in the following analysis of health and community action.

Of the fourteen families in the sample, two couples were childless, and one family was represented only by the wife, the husband having died about twenty years ago. A total of 107 children were born to these twelve families, ranging in number from five to thirteen per family. The average number of children born per productive family was slightly less than 9, and for the sample as a whole 7.6. The average number of children living per family was 7.4. The age of the children ranged from 10 months to 33 years, averaging 11.4 years.

The age of adults in the sample ranged from 33 years to 86 years, averaging 43.1 years.

Family stability was found to vary from the stable permanent marriages, which numbered eight, to situations where recurring desertions by the husband were experienced. In three families, repeated desertions of the wife and children have occurred throughout the years, creating for all purposes matri-centred families such as those found among lower-class whites (Miller 1958: 6). One husband left his wife and children on one occasion several years ago but returned within a few months. Another husband deserted his wife and children four years ago and has not returned. In yet another instance, the husband was absent from the home for a year because of a bootlegging conviction. During periods of desertion the wives and offspring are supported by provincial allowances, one of the most common types of welfare assistance on the reserve.

The adults' education ranges from grade six to grade ten, and occupations fall into the skilled and unskilled labour categories. Five men are skilled labourers (e.g., machinists, welders, iron casters, and assembly-line workers) who commute daily to factories and shops in the nearby towns. Five are unskilled workers and, unlike the skilled men, maintain only sporadic employment at best. One man has been permanently unemployed and supports his family on his Veteran's Allowance and a Mother's Allowance his wife receives. Two men permanently farm, and another owns and operates a store on the reserve. The only two women who work permanently are both employed part-time off the reserve, one in a fruit-canning factory and the other as a cleaning woman in a private home. Although many of the women work, or have worked, on a part-time basis in the summer picking berries, this seldom measurably increases the family income, which ranges from less than $2,000 a year for those dependent upon welfare to slightly over $8,000 a year.

Incoming money is sometimes carefully allocated to needs and wants; in other cases it is spent soon after it is received, leaving the family "short" until the next pay day. In addition, and unlike the elite, the extensive use of alcohol by four of these men places a heavier burden on the earned income, requiring the women to be even more careful when buying food and clothing. Reliance on unemployment insurance is not uncommon for a few families during the winter season and is completely lacking among others. Economic independence of the nuclear family is valued, but not to the extent that it is among the elite; to some, the need for welfare is not a fact to reveal to an interviewer, and to others it is not a fact to hide.

The lower status style of life is much less elaborate than that of the elite. Their houses range greatly in size and type of construction: some are extremely crowded with their large families; others provide ample room for both work and play. Eight houses were built and financed by the family, two were rented, and the remainder were welfare houses. Despite the common use of the term "welfare houses," by no means all those living in such houses are of lower status. Families are expected to purchase the houses from the Council through instalments suitable to their incomes. These instalments are made very small, and often a token payment is accepted by the Council as some indication of good intention. Until recently the Council had dealt leniently with those who made no attempt to contribute to the cost of the building. In one instance, however, the Council did sanction and enforce the removal of a woman and her family from a welfare house because no effort was made to reimburse the Council when it was known that funds were available to make at least a small payment. In this case, the Council had gone to extreme measures to equip the house with facilities not generally a part of the welfare program because the woman was handicapped by a permanent disability. Recurring desertions by the husband left the wife with five (later six) small children subsisting on welfare allowances and, when the husband did return, the payments he agreed to make toward the house did not materialize. The eviction received inaccurate and unfavourable publicity in a city newspaper, which evoked much indignation on the part of the Councillors. It also served to stimulate statements from the Councillors and the elite that if such individuals even "tried," this course of action would not have been necessary.

The houses of the lower status in general are in a poorer state of repair than those of the elite, and most are sparsely furnished with upholstered furniture, and little or no floor or window covering in some cases. Although electric appliances or gas stoves are found, there is not the total complement characteristic of the elite. Woodburning kitchen stoves and house-heating units are not uncommon, nor are refrigerators and sinks common kitchen equipment. In one house, for example, a son had given his mother a modern gas range with superimposed rotisserie, a large freezer, and an electric frying pan, which he had bought with funds earned by welding in a Brantford shop. But at the same time the home lacked plumbing facilities, a sink, and a refrigerator.

Almost all houses are equipped with electricity and a telephone, but these facilities are usually "out of order" among the lowest income level families. Though all families have radios (transistor types being most common), only seven have televisions. Seven women have sewing machines, and most have washing machines (two have simply washing tubs) of the older wringer type.

Since, unlike the elite, they are interested in food rather than diet, the main concern of the lower status family is the quantity of food rather than its quality or nutritional value, a matter that is poorly understood. Though diet varies according to time of year and income, it includes mainly starchy foods with potatoes, bread, and macaroni as the staples, as well as the cheaper types of meat—sausage, hot dogs, hamburger, and bologna. Protein foods such as milk, eggs, cheese, and meat are often considered too expensive, and Freshie is frequently substituted for milk, especially during the summer months, even for infants. Gardens, a potential food source, are kept by only three families.

Since refrigeration facilities are generally either non-existent or inoperative, spoilage must be and is taken into consideration both at times of food buying and in types of food purchased. With small incomes and large families, waste of food is not a minor matter to the women. Vegetables, canned or fresh, with the exception of potatoes, are not a significant dietary element; nor is fruit, although if the parents have been "picking" they may bring some fruit home during the summer season without cost. Sweet foods such as cakes and cookies are a frequent diet component, and money may or may not be given the children for candy, depending on income and attitude of the parent at the moment. Frying of foods (meat and potatoes) is the usual method of preparation, according to the public health nurses, and in regard to long-term preservation of vegetables and fruits, except for two families who have gardens, the lower status women are neither economically able nor inclined to do so. Among the elite and some lower status women, canning is still undertaken to a moderate degree, but nothing comparable to the earlier decades. The freezer has replaced the more laborious canning procedures, but most of the lower status women do not have freezers.

The social stigma of the unwed mother, very much a part of the elite's social and moral ethic, is inoperative in this group to the extent that the existence of illegitimate children is revealed openly to the field-worker. In all the cases studied the children were kept by the young mother and taken with her when she married. Three families contained illegitimate children of the mothers; in two of these, the mothers indicated that the relationship between the husband and their own illegitimate offspring was not harmonious. In one case, the mother stated that her son's leaving home had not displeased her because "he and my husband don't get along too good." In talking of her oldest daughter, another mother commented that her husband "is always so mean to her; he's always saying nasty things to her, but he treats the other kids differently."

In addition to desertion and the presence of children not from common parentage, excessive use of alcohol is a very frequent disruptive factor in lower status family life. The Royal Canadian Mounted Police have been called to two homes by neighbours because of "noisy drinking parties," and the Children's Aid workers and other welfare officials have sometimes followed with inquiries involving child neglect. During the period of field-work all the children in these families lived with the parents; none had been removed despite inquiries.

Despite disorganization on account of excessive drinking, family relations between parents and children are seldom characterized by brutality. Children are loved, though sometimes just tolerated; but unlike the elite's children they are seldom the centre of attention. Often older siblings care, feed, diaper, and dress the infants and younger children. In these cases much of the discipline is exercised by the older siblings with little sensitivity to the ideas of child care; often resulting, according to the parents, in "spoiled" children.

According to the public health personnel, weaning (bottle feeding is the most common method), introduction of solid foods, and toilet training tend to be attempted by the mothers later in a child's development than among the elite, and scheduling of feedings and sleep is very rare.

Birth control procedures, which involve both expense and a degree of future orientation, are either rarely utilized or utilized inconsistently in the early years of marriage. It is invariably to terminate already large families, rather than to space children or control the numbers that these procedures are adopted.

The lower status parents vary greatly in their concern about their children's progress in school. In one family, for example, the mother became disturbed when one son was sent home from school for the day because of his failure to take a current event clipping to class. She assisted him in locating a newspaper clipping and wrote a note to the principal, stating her disapproval of the child's having to miss an entire day of school for such an omission. In this same family, the parents made considerable sacrifices to provide their children with an encyclopaedia and some sports equipment.

Academic achievements may be a source either of great pride to the parent or of passing interest, depending on the parent's aspirations for himself and his children. Pressure to induce children to continue in school varies greatly, from parents who have no such aspirations to those who show great concern about the prospective drop-out. In the family that had been deserted by the father, for example, the mother was strong in her determination that her children, including the girls, receive sufficient training to support themselves. Her concern for the girls reflected her present situation of need for employment, and her lack of skills to obtain a steady job. In another family, the mother did not place much value on education, claiming that she "guessed" it "might help." For girls, she felt it was "a waste because they just get married." Parental aspirations for their children's future occupations are minimal, the decision being left to the child as among the elite.

In families having sporadic incomes, immediate employment is often the desired goal both of the parent for the child and of the child himself. Working adolescents may be expected to contribute to the family support, particularly in "hard times." Education is not seen as an avenue to higher and more stable financial reward. One mother, for example, remarked that she was "happy" when her oldest son left school to pick cherries in Rochester. She was proud of her son's success in obtaining a job and felt that he was "better off" out of school where there was "too much delinquency."

Eight of the families are Anglican, two are Baptist, two are Pentecostal, one is United, and one has a somewhat mixed affiliation. The husband maintains a tenuous tie with the Upper Cayuga Longhouse, and the wife claims no affiliation despite having been raised as an Anglican in the Mohawk Institute. Only one couple regularly attends church and consistently participates in church affairs. Three other families send their children quite regularly to Sunday school but only rarely attend themselves.

Adult ties with community associations other than the church range from the very tenuous to the nonexistent. A few adults have joined one or two associations in the past, and although in some cases the commitment appeared to be strong at the time, membership was short-lived and no leadership roles were assumed. One woman claimed she discontinued her membership in the Women's Institute because at that time she was living as a common-law wife with her husband, and she did not want to "embarrass" the women in the group. She later added that a few of the women were "uppity" and "talked about" her, and consequently she felt it was "better" to withdraw. Another woman, although not a member of the organizing committee, used to chaperone the "Teentown" dances, held in the community hall on Saturday evenings. Her husband said she was "a damn fool to waste her time," but she felt that it was "safer" for her teenagers to attend the dances despite the "drinking that goes on," than "to be out on the roads somewhere." A third woman devoted much of her spare time to assisting in fund-raising campaigns for the Mohawk Workers, although she did not participate in the Pageant drama, sponsored by this group each August. Three men in the sample have participated in community affairs, but, like the women, their commitment was of short duration. One was elected to Council for a single term but did not again run for office. Another was a member of the Ploughmen's Association but withdrew when he no longer entered the competitions and left farming for wage labour. The third involved himself with the Six Nations Community Project, but, as he said, "washed my hands of it" when the Council denied recognition to the group. Participation in local politics varies considerably—from the Mohawk Worker who refuses to vote in local and external elections, to the couple who "aren't that interested," or the man who ran for Council.

In addition to those families who have temporarily belonged to community groups there are some whose very knowledge of the existence of these groups is scant. The only organization that one wife knew about was the Welfare Committee of the band Council. Social activities tend to be confined to kinsmen and friends in informal situations. As Cohen writes,

> In general, the working-class person appears to be more dependent upon and "at home" in primary groups and to avoid secondary, segmental and formal relationships more than the middle-class person (1955: 97).

Medical beliefs and practices

In contrast to the elite, the lower status infrequently organize their daily living routine with good health as a desirable goal in mind. They seldom attempt to set up barriers against agents that promote disease, evidencing not so much their supposed lack of "care," but their lack of knowledge about the danger of these agents as disease carriers. In cases where they have been informed of the hazards, they infrequently or inconsistently take any action designed to alter their present conditions. The general nature of most of their houses and surrounding grounds, for instance, acts to inhibit good health: the unsafe well water they drink, the lack of covering of the well itself, the lack of screening for doors and windows to prevent insects from entering the house, the state of disrepair of the privies, and the irregular heating of the house in winter.

Plate XII. Pageant play of Joseph Brant in 1957 at General's Woods. L to R: Jim Schuler, Andrew Jamieson, Arthur Anderson Sr., Alex General and Ardie Johnson. (Courtesy Mr. Arthur Anderson Sr.)

Some families also neglect the aspects of general personal care so important to the maintenance of good health. The irregularity of meals and the heavy reliance on fried and starchy foods inevitably lead to a decreased bodily resistance to disease. The lack of importance placed on household cleanliness tends to aggravate conditions of ill health when they do develop.

As they are oriented to gratifying immediate needs, the prevention of illness does not take on the magnitude among the lower status that it does for the elite. This time orientation is only one part of their health perspective, however. There appears to be little acceptance of a relationship between the nature of drinking water and ill health. During one visit I made to a family, the father asked the public health nurse to test the well water. When she saw the miscellaneous debris floating on the surface of the water she inquired whether the man thought his well should have been tested earlier. He replied "It hasn't killed us yet." The relationship of good water to good health, which tends to be accepted on faith by most people, is of lesser consequence to the lower status families than to the elite. Indeed the significant overriding problem of the mere availability of water often reduces the importance of the quality of the water itself.

This "quantity rather than quality" preference of the lower status equally applies to food purchasing. The connection between diet and state of health appears to be poorly understood. The relationship of food intake, particularly of fried foods, to gastric discomfort is repeatedly explained by the physicians, as is the link between starchy foods (particularly potatoes for breakfast) and overweight, especially during pregnancy. In both instances, however, abstinence from such foods or methods of preparation is temporary, and the foods recommended as substitutes are poorly remembered. Diet changes fall into the area of removing discomfort and are rarely made with the purpose of maintaining a better state of health. A major factor that cannot be disregarded is the low family income, which must be spread thinly to feed the large families. The women seldom buy canned baby foods, and, when they do, canned meat, which is more nutritious but more expensive, is rarely one of these items. The young children eat the same solids as the rest of the family.

In general, the seeking of medical assistance depends initially upon the recognition of certain bodily signs as indicators of illness, and this judgment, as Paul (1955: 6) has noted, "is determined as much by cultural definition as by the intrinsic nature of the ailment." Recourse to action then follows if these symptoms are assessed as significant enough to be brought to the physician's attention. Among the lower status group, economic considerations are removed from the decision to contact professional aid, and the factor of transportation to the hospital appears to be a minimal deterrent.

Certain bodily reactions are expected in certain situations and are considered normal occurrences; hence they are believed unworthy of professional attention. Dizziness and nausea during pregnancy, for example, are often thought of as simply a part of being pregnant. Medical assistance is sought only when these conditions become severe, as when the woman "blacks out." The pattern of reporting upper respiratory infections for both adult and child is just the opposite. In the great majority of cases reported at the hospital, the adult or child had suffered from the infection for less than three days, and usually one or two days. Most of the lower status mothers are cognizant of the prevalence of pneumonia among children, and consequently they tend "to stop it from coming" by obtaining medical treatment for common colds. For most of the common cold and cough complaints, white pine cough medicine is given to the parents, and there are requests for this medication when a prior consultation has not occurred.

Diarrhoea, the most common gastro-intestinal complaint, is particularly prevalent during the summer months, and infants are frequent victims. Being endemic it tends to be classified as an expected condition that will eventually go away, and one that is not particularly dangerous Some infants will have had this complaint for a week or more before assistance is sought, if it is requested at all.

Accidents (burns, poisonings, and contusions, usually inflicted by older siblings), frequently more severe than among the higher status, are brought to the attention of medical specialists soon after they happen and are of no little worry to the mothers. After these accidents, hazards are usually removed.

For those who do take preventive measures in the home, diet and the regulation of heating (mostly by wood-burning stoves) do not figure in these precautions. These families, particularly the women, are, for the most part, aware of the dangers to health (stressed by the nurses) in water and milk, but unless there arises some manifest sickness directly connected to the intake of these liquids, treatment to render both "safe" is not made. One family drank milk from their own cow. "We drink it raw. I know I should boil it, but I don't. I did when the children were small." This same family, on moving to a new location on the reserve, built their own well with tiles obtained from the Council and had the water tested. The mother informed me that her children had contracted infectious hepatitis from a neighbour's well prior to the move and that she did not want a recurrence of the illness among her children. Their well, however, was tested only once after they had dug it. Another woman had had her well water tested on the urging of a public health nurse who felt that diarrhoea among their children might be deterred or lessened. The instructions the nurse gave the woman were quite simple, but the woman failed to remember them ("She told me to put something in the well, but I forgot. I think it was javex") and consequently took no action. It appears that unless the women take some definite stand on such issues, precautions are not taken by the men, and in some cases where the women do take a position, they find difficulty in convincing their husbands of the need for the extra expense of screening or of rebuilding the privy or well.

Preventive measures, if taken at all, tend to be confined to the sphere of pharmacopoeia. One mother, for example, was giving her son cod liver oil one winter because "he had so many colds in the summer." Vitamin pills, if given regularly or at all, are given to children who are most frequently sick. Well Baby clinics are attended irregularly. The mothers are, however, anxious that their children be immunized, and request "needles" during the public health nurses' visits or bring the children to the hospital of their own accord. Despite the desire to have the children inoculated, most of the mothers do not know the different types of diseases against which their children are being protected.

According to the physicians, the disease pattern on the reserve does not differ from that found among whites of similar socioeconomic conditions. In 1965 the ten most frequently treated conditions among in-patients were as follows: respiratory infections, heart disease, pregnancy, diabetes, anaemia, enteritis and gastritis, injuries, skin disease, convulsions and throat infections. Among out-patients the most frequently reported problems were respiratory infections, infantile diarrhoea and feeding problems, diabetes, heart disease, and injuries. Because of the absence (as in the case of smallpox) or minimal occurrence of diseases against which infants and children are immunized, it is not surprising that the mothers are unaware of the nature of these diseases. The immunization program rests largely on "faith," as one public health nurse phrased it, a willingness to take precautions against "the unknown."

Regarding prenatal care, lower status women vary greatly in the degree to which they take advantage of the monthly services at the hospital. One mother stated that before the clinics were introduced in 1957 "I never went to a doctor until it was time to go" (to deliver). Of the clinics she said: "They give you vitamin pills, check your blood pressure and stuff like that. If you are healthy, you don't need to take the pills. I didn't make a habit of it. I took them when I thought of them." The first contact with a physician during pregnancy is usually made around the fifth or sixth month, and is usually prompted by some complaint such as dizziness, nausea, and the swelling of joints. This general pattern of clinic use (*see* Table 7) again underscores the pattern of turning to preventive measures after some discomforting event occurs in order to prevent further occurrence. In one such instance a woman miscarried in her sixth month and was told by the physician that this might have been prevented had she had some check-ups. Since that time she has gone to the hospital prenatal clinics during the third or fourth months of pregnancy.

Symptom development is an area of perception that varies with the parents' sensitivity to changes in children's behaviour and appearance, and with their experience with illness. Usually the mother is the family diagnostician, as she is among the higher status, although in a few instances reported by the women it has been their husbands who noticed certain changes in the child's condition. Symptoms such as a "runny" nose, wheezing, coughing, convulsions, and skin rashes are easily brought to the attention of the mothers, and usually bring consultation with the physicians. More subtle changes in a child's condition such as a relatively high temperature are not so easily noticed by the women unless the child is obviously flushed. As thermometers are a rare item in the households, no empirical proof of a feverish state is obtainable until the condition is quite advanced. Literature in the home on medical matters is scant if present at all (some women use *Canadian Mother and Child*, a

Federal Government publication); relatives, neighbours, and friends are often consulted about the meaning of symptoms before public health personnel or physicians are contacted.

There is a great variation in the amount of "doctoring" done in the home both before and after medical assistance is sought, and there is a slightly greater reliance on the hospital dispensary items than found among the higher status. The drugstores are used to provide such things as pain relievers, laxatives, metholated rubs, and, to a lesser extent, disinfectants and band-aids. There are three families that often purchase such items from travelling salesmen. Cough medicine, however, which is usually obtained from the hospital, is believed to be much superior to the patent brands on the market.

Disease causation is of varying concern to these lower status women, who talk in terms of "germs," and "catching" a disease from another person, and "getting sick from bad water." They also speak of "nerves" causing headaches and stomach upsets. In comparing the health of their children, they recognize that some children are more susceptible to illness than others ("If something is going around he always gets it"). They are reluctant to state whether this susceptibility is inherited and apparently are undecided on the issue. Causation is seen primarily in terms of natural phenomena and secondarily in terms of socially induced "nerves" or "tension."

The use of Indian medicine varies from complete rejection to the use of it for specific types of illness or injury. Families that use it on occasion invariably have close conservative relatives from whom they have learned the remedies. In one family the father, who is a non-active adherent of the Longhouse, regularly collected coltsfoot[9] in the summer to be used when his children developed colds. Although his wife rarely resorted to the use of Indian medicine, she did so on one occasion when she had severely cut her foot with an axe (she also received medical treatment at the hospital). She applied the commonly used crushed plantain leaves[10] over the cut in poultice fashion and later claimed that the absence of a scar was due not to the hospital treatment but to the plantain poultice.

A second woman, whose mother was a conservative, utilized Indian remedies in addition to modern medicines while her mother was alive. From her mother she had learned how to recognize many plants and prepare them for use, but since her mother's death, some eight years ago, she has seldom resorted to these concoctions: "It takes too much time to hunt them in the bush, and then you have to get them ready. I'm too lazy; it's easy to get medicine from the doctor." However, she certainly believes in the efficacy of many of these remedies: "There is a lot of power in those medicines, you have to be careful with them. But they won't work, you know, if people drink. It kills the power." This woman and her husband are regular church attenders, and he is a member of both the choir and the church business board. He was raised a Christian but has resorted to Indian herbal remedies on occasion in the past. Some fifteen years ago, for instance, after being kicked in the forehead by a horse, he suffered severe headaches, which the physician was apparently unable to alleviate. His wife's mother prepared a "fish feast" with fresh fish brought to the house by his brother, who had been on vacation in northern Ontario. They did not tell the husband about the preparations, but he willingly cooperated when the cooked fish was presented to him. He claimed that "it helped his condition." According to his wife, the feast had been somewhat unorthodox, but they later humorously viewed it as an attempt that had surprisingly proved of some use.

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[9] *Petasites palmatus* is a type of coltsfoot that is found in southern Ontario (Montgomery 1962: 167).

[10] This informant, like most non-conservatives, could not be specific in a description of the type of plantain used. Many varieties of plantain are common in southern Ontario, *Plantago major*, *P. rugelii*, and *P. lanceolata* (Frankton 1963: 138).

Another mother claimed that she had used catnip[11] "for fever." The plant was given her by an aunt who was a conservative. She was instructed to boil it in the amount of water that half-filled one of her saucepans and to give two teaspoons to the infant when the liquid was cool. Although raised in the Mohawk Institute from early childhood, and claiming Christian affiliation, the woman has been sporadically influenced by her maternal aunt. It appeared that if the relationship with the aunt were not continuous, the using of Indian remedies would likewise not be continuous. The mother stated that she thought the catnip liquid "helped" and claimed that she used it only once because "I can't get it." When asked if the aunt would have provided her with more plants, she said "Oh yes, she believes in the stuff." The same child on whom the catnip had been used was weaned from the bottle "the way the Longhouse people do, by the full moon." She felt that this abrupt method was "hard on the mother for a day, and then the baby stops crying." She had weaned two other of her thirteen children by this method, claiming that the method she chose depended on "how I feel." The mother does not attend the Longhouse "doings," nor does she appear to have much sympathy for their customs: "You know, they don't practice what they preach." She claims affiliation with the Anglican church, as does the father, but neither attends, nor do they send their children to Sunday school.

Reluctance to use Indian remedies is demonstrated in a statement made by another woman: "I've never really used Indian medicine. I always take them [the children] to the hospital. They know best there. My father didn't believe in Indian medicine. There are so many things that can make you sick, like poisons."

In the remaining families, which significantly do not have close conservative relations, Indian medicine is not used on any regular basis, but one woman, now in her eighties, in addition to consulting physicians on the reserve and in Brantford, did make extensive use of it when she was first married at the turn of the century.

Diagnosis in the home is made on a very simple basis of past experience, analogy, and pooled knowledge of friends and neighbours. In one such instance a woman said that when her son began to act "strangely," have a "runny nose and runny eyes," she thought that he was "coming down with a cold." She gave him cough medicine she had on hand, but this had no effect. "But when he broke out in red spots I knew what it was. When the others got runny noses I knew they were getting it. You know you can go blind with them

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[11] Catnip—Nepeta cataria (*Webster's Third International Dictionary*, 1959)

[measles]." She went on to say: "Donald, the one with the asthma, got delirious. I phoned the hospital, because it was after hours. They told me to bring him in. They gave him a shot of penicillin. I'm glad I took him to the doctor because he got better more quickly." But when asked what type of measles her children had, she was not aware of the existence of different types. This is not uncommon among lower status women, nor is the lack of understanding of the harm of contracting measles during the early stages of pregnancy. In another case this use of analogy with a common illness, flu (associated with vomiting), caused the mother to try to cope with the illness at home, expecting it "to go away in a day or two." "Ronald got it worst of all. He got so thin. Even the smell of food upset him. Especially fried things. I finally took him to the doctor and he had [infectious] hepatitis. The doctor gave me a diet, and when the others got it I put them on the diet." In some cases this analogy method works, but when it does not, a considerable interval often elapses before medical assistance is sought.

Those regularly dependent upon welfare support have a different attitude toward the medical personnel than the families that are economically more viable. This attitude is manifested in a demanding behaviour in the therapeutic relationship: welfare personnel must cope with lower status persons who feel that certain services are "owed" them. When these services are not seen to be forthcoming or are judged unsuccessful, it is interpreted as an unwillingness on the part of the medical personnel to attempt to help. This attitude is also affected by an often unrealistic assessment of medical technology and an apparent implicit belief that there is a cure or partially effective treatment for every ailment. In one such instance a woman claimed that she did not attend the prenatal clinics because "the nurse wouldn't do anything" about her nausea. This same woman stated that the physicians "wouldn't do anything" for her arthritis, which was progressively spreading to previously unaffected areas of her body.

This demanding behaviour of welfare recipients is also experienced by the nurses when the patients are hospitalized. According to some nurses these individuals tend to be unappreciative of nursing services. Consequently they are not looked upon with enthusiasm when they are admitted, largely because they call upon the nurse to do tasks which they could well do themselves. The doctors reflect the nurses' attitude. They feel that these patients in particular fail to appreciate either the quality of care they receive, or the costly drugs they are given without charge.

The lower status welfare dependents appear to look upon hospitalization as a pleasant experience after the discomfort has been alleviated. This is particularly evident in their pleasure with the types of food they usually do not have at home, especially ice cream. Hospital experience is somewhat of a "luxury" to these people, as Koos has noted among his Class III or lower class residents of Regionville (1954: 81).

The attitude of the remainder of lower status families toward medical personnel, although varying with each person's personality and past experience with the hospital, is in general one of respect. In these homes the public health nurses are not presented threateningly to the children as much as they are among welfare recipients, where in one instance a mother sharply reprimanded her son for "acting up" and told him that unless he behaved himself "the nurse will eat you up." The threat of the "needle" is also used in the lower status homes, mostly by the welfare families, despite the nurses' attempts to the contrary. The doctor is believed to be the most authoritative figure in the medical field, and hence the one to consult in times of need, rather than the public health nurses. But perhaps even more important than the doctor's image as a skilled and knowledgeable figure are the "good medicines" he prescribes. "They have good medicine there, heaven knows they give you lots of it, and it's free. They have good cough medicine for kids."

Despite this generalized respect for the doctor, parental confidence tends to wear thin when the prescribed regimen and medication do not alleviate the patient's condition. One mother, in relating her experience with an asthmatic son, claimed that one ought to "give the medicine a chance." On three separate occasions she had taken this son to the hospital because his "wheezing worried [her]." Each time, the physician gave her a different "pill"; the third type of medication produced a severe reaction in the child, who "turned blue and then purple around his mouth, his lips and his tongue, and he was swelling." She immediately took the child to a physician off the reserve who prescribed some medication to reduce the swelling, and some additional pills for the asthmatic condition. For over two years she continued taking the son to this doctor, claiming that "the last pills I got at the hospital were too strong. I thought the next might kill him."

Unless considerable discomfort is involved, medication is seldom taken consistently, and the physicians' requests for return visits are rarely heeded. In one such case a man called at the hospital and explained to the physician that it "feels like my lungs." After insisting that an X-ray be taken, he waited impatiently for a few days until the hospital was able to notify him of the nature of his condition. "They told me I had a touch of pneumonia and to come down and pick up some medication. I felt better by that time and was back working so I didn't go back."

Surgery for both adults and children, as among the higher status, is thought of with apprehension, aggravated by lack of confidence in some of the physicians. In one case a woman commented on how she was "really scared" when she was being anaesthetized for a minor operation. "I thought, what happens if I never wake up again. But I did. My husband, he always wants me and the kids to go to Hagersville. But we have no car to go in." She later added that if she had had "faith" in that particular physician's ability, she might not have been so concerned. This fear, interestingly enough, does not apply equally to childbirth. Delivery is seen as a normal event in a woman's life and considered a rather unchallenging task for the physician.

Regarding the nature of one's involvement in the health-illness complex, the lower status have a threefold classification: "sick," "sickly," and "healthy." A healthy person is one who is essentially active and able to carry on the normal routine of life without any limitations. In addition, to be totally healthy one must have full control of his mental capacities, that is, be able to cope with daily activities without the aid of others. In a child, this is manifested in reasonable progress in school; a slow learner would, in their terms, be neither "really healthy" nor "really normal." But the lower status mothers' understanding of mental illness is rather nebulous. Epilepsy, an illness uncommon on the reserve but not unheard of, is a source of wonder to the women, who apparently have few thoughts about the causes of such ailments.

A man who can undertake daily routine such as maintaining a job, or a woman who can carry out household responsibilities is considered sickly if his or her leisure activities are restricted by debility, which is usually of a chronic nature. One woman claimed that her daughter was "healthy" because "she is running around all day long and never gets colds . . goes through winter and summer without getting a cold." Her son, conversely, she described as "weak," because of his chronic asthmatic condition and his susceptibility to colds and sore throats. A neighbour with "heart trouble" she likewise described as "sickly." His skin is pasty coloured. He works in town all day and comes home beat. He goes to bed right after supper and then gets up and goes to work."

Another woman described herself as "sickly" during one of her pregnancies. She was anaemic for most of the nine-month period, experienced morning sickness, and suffered from jaundice during the latter stages of pregnancy. She "dragged around" the house for most of the time, not able to undertake her usual household chores with any enthusiasm or stamina. It is only in this category of "sickly" that chronic conditions are given any recognition.

A sick person is one who is suffering from an acute form of illness and is temporarily restricted to the house, and in most cases to bed. With the exception of the welfare recipients, who apparently allow more free expression of the sick role in both children (absenteeism from school) and adults (sporadic participation in the Winter Works project), the sick role is one that is not easily allowed an individual but is more readily granted a child than an adult. A sick child is pampered to a high degree, is fed what he likes (in some cases without regard to diet restrictions), but is seldom allowed to maintain this role when he does not physically or mentally merit it. Mothers relate that if one child relies on this role for special attention the other children "make fun of him" and "call him a sissy," so that group pressure from his own family tends to inhibit the maintenance of this role when it is undeserved. The parents also tend to go along with this attitude, for in many cases they lack the time to devote to a continuously demanding child.

As for the curative aspect of the disease development continuum, most lower status adults recognize a "cure" as the permanent removal of symptoms. Chronic conditions are seldom said to be "cured" by medication, only "helped." These are conditions that "have to be lived with." But unlike the higher status families, two lower status families have on occasion resorted to "faith healing" by Pentecostal preachers. In one case, the mother had fallen on her knees while getting out of a car, and subsequently suffered severe pain, which the physicians were not able to alleviate. Some weeks later she attended a "prayer meeting" held on the reserve by a visiting "coloured preacher from the States," who was able to cure her. She claimed that he had, in fact, "cured me" despite the continuing pain from osteoarthritis, which was slowly crippling her. In the second family, the oldest son had sprained his thumb while playing in the barn. Although taped at the local hospital, the thumb continued to cause him pain, and his mother consequently had her husband's uncle, a Six Nations preacher, "cure" it during a prayer meeting at the local church. Both these women and their husbands had confidence ("faith") in the curative powers of both the preachers and the supernatural, and in both cases had resorted to these measures when the physicians were unable to remove the symptoms.

In conclusion, it is noteworthy that although the elite disapprove of those who frequent the local hospital for what they consider to be unwarranted complaints, the analysis of medical histories of fourteen families (five higher status and nine lower status) did not indicate that the lower status used the hospital significantly more frequently than the higher status (*see* Table 9). Nor have the higher status established connections with private physicians in the nearby towns to a significantly greater extent than the lower status families. Fifty per cent of the higher status families (sample of 30) have family doctors, compared to 42 per cent of the lower status families (sample of 14).

Among adults, the higher status averaged 21.6 visits per person over the fourteen-year period, compared to the lower status average of 28.2 visits (*see* Appendix B for medical history sampling). The higher status child averaged 11 visits, compared to the lower status child's 16.8 visits. Nor did the proportion of hospital admissions to total visits differ significantly between the two status groups. Among the higher status adults, 13.4 per cent of the visits resulted in admissions, compared to 13.2 per cent for the lower status.

Table 9

Hospital Use by Non-Conservatives, 1952-1966

Status	No of Persons in Sample	Out-Patient Visits	Average Visits	Admissions	Admissions as % of Total Visits
Children					
Higher	20	220	11	12	5.5
Lower	40	673	16.8	56	8.3
Adults					
Higher	10	216	21.6	29	13.4
Lower	18	508	28.2	67	13.2

Among children, 8.3 per cent of the lower status visits resulted in hospitalization, compared to 5.5 per cent for the higher status children.

The major difference in hospital use was found in the point in symptom development at which medical assistance was sought and, to a qualified degree, in the types of ailments reported. Both status groups reported upper respiratory ailments and accidents most frequently, and in similar proportions to the total number of visits made. But only the higher status consistently utilized the hospital as a source of information on what could be termed "fringe" medical conditions. These included such things as inquiries about minor bone defects; tests for Q-fever,[12] initial immunization and booster shots for children in preparation for school or summer camp; mothers' questions about weaning procedures; problems of obesity, particularly among women; concern about poor vision among children and scars on noticeable parts of the body; questions on how to prevent children from biting their fingernails; and requests for information on birth control procedures. Most of these queries involved non-acute and non-chronic conditions and concern about one's personal appearance.

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[12] The relationship between wood ticks (*Dermacentor variablis*), which are found "in great concentrations on a number of Southern Ontario reserves," and certain diseases such as tularemia and Q-fever has been under study for the past few years by researchers from the Zoonoses Laboratory of the Federal Government (pers. comm., Dr. M.L. Webb, Acting Zone Superintendent for Southern Ontario, June 4, 1965). The wood ticks are believed to be carriers of these diseases and are thought to transmit pathogenic organisms to cows who, in turn, transmit them to humans through their milk. In 1964 the testing of dairy herds on the reserve revealed two known cases in which the milk contained these organisms. The families owning these herds and drinking the unpasteurized milk were requested to have their blood tested at the local hospital. One family of nine children complied with this request; the other refused, the mother opposing "experimentation" on her family, although the husband was willing to submit to the blood tests. Neither of these diseases, moreover, are considered fatal, although "tularemic infection constitutes one of the most common causes of pneumonia" (Brown 1957: 766).

Chapter VI

Community Action and Health

The two main medical issues at the community level, hospital policies and practices and sanitation innovations, became the foci for group activity in the late 1950's and early '60's. Commitment to these issues came from predominantly higher status individuals, who are most health-conscious. Mobilizing around these two issues, however, were two very different alignments of non-conservatives with two very divergent perspectives of medical matters. At the community level of organization there were two streams of activity proceeding simultaneously for most of this time.

Involved in hospital matters were non-elite higher status persons some of whom were in the capacity of Councillors. The first action in any regard taken at this community level was instigated by the Council. The structuring for this reaction, which came from the pre-existing sub-committee organization of the Council, took the form of three committees created in serial order. Involved in sanitation matters were the elite (in leadership roles) and the non-elite higher status (in membership supportive roles). Two sanitation committees developed consecutively which, although working independently of the Council, depended upon Council approval and financial support for the fulfilment of their objectives. That this authorization was not immediately forthcoming was, among other things, clearly a product of the Council's involvement in the "hospital situation" and of its divergent attitude toward the locus of responsibility for health programs on the reserve. Other factors contributing to the tension between the Council and the elite will be presented at the close of this chapter.

Both types of committee activity ultimately stemmed from externally derived Federal Government pressures to alter the medical standards on the reserve: pressures on federal hospital personnel to update the hospital and medical service financing, and on some Six Nations residents to establish a public health program. When plotted along a time continuum from 1950 to 1966, the committees originating within the political arena give evidence of a series of differing responses to these rapidly introduced medical changes. This progression of slowly changing reactions can be grouped under four headings: (1) verbal rejection, (2) organization for opposition, (3) failure of opposition, and (4) accommodation.

From 1950 to 1955 the reorganization of the hospital and later the inauguration of new financing policies for medical services were undertaken (*see* chapter V). This was a period of opinion formulation, largely characterized by a new assessment of the physician's role. The period from 1956 to 1961 was marked by (1) a rejection of the proposed group hospital insurance plan for the band and the refusal to participate in a survey sponsored by the Federal Government, designed to eliminate the ineligible families from the Agency's group plan (*see* p. 85); (2) a request for the removal of a physician; and (3) the formation of the Hospital Committee. The period from 1962 to 1963 was characterized by intensified attempts to alter the new medical policies and practice (1) by organizing a delegation to express the people's complaints to the Minister of National Health and Welfare in Ottawa; (2) by calling for a formal hearing of residents' complaints about the treatment they received at the local hospital; and (3) by instituting a Complaints Committee as a sub-committee of the Council. The two-year period of 1964 and 1965 was as much a reaction to earlier attempts to alter the course of events as it was a reaction to the outside pressure itself. These two years were marked by a realization of the failure of efforts to correct the unpopular policies. The final period, still in its initial stage at the time of writing, began in 1966 and witnessed the apparent acceptance of the administrative practices to the extent that attempts to oppose the administration have not been made.

The reaction of the Council to the external pressure is depicted schematically in Diagram D. The two sanitation committees have been placed in time perspective in this diagram, giving a visual indication of their position with regard to events occurring at the political level of organization.

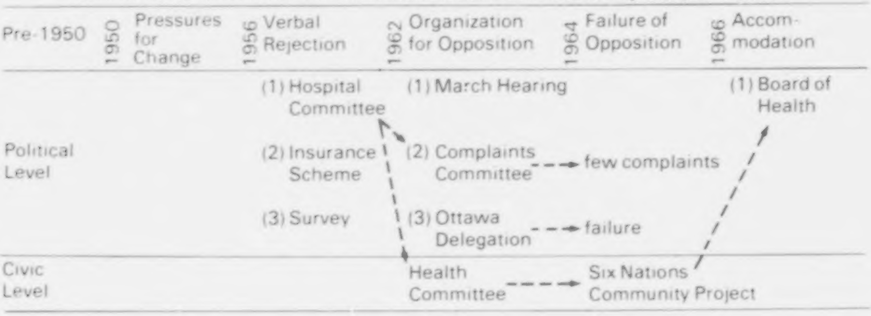
It is evident from this diagram that the appearance of the Health Committee, in some respects a continuation of the Hospital Committee, occurred at an inopportune time to make demands upon the Council. The history of these sanitation committees will be discussed following the presentation of the Council's reaction.

The Hospital Committee, the first in a series of committees organized by the Council, was appointed in the spring of 1956, largely in response to the hospital's billing procedures.

Apparently from a suggestion of a white resident missionary, the same person who later undertook the hospital insurance survey, this Hospital Committee was created for the purpose of formally establishing a discussion group to act as a liaison between the Six Nations Council and the hospital. Although no formal charter or constitution was ever set down for the committee or by it, it was generally understood that its aim was to "smooth out" the disruptive relationship between these two bodies, which had vastly different perspectives on the reserve medical picture. The committee was to be a connecting link through which the Councillors and the hospital administrators could communicate. One hospital administrator hopefully phrased the committee's aim as "to see our [the hospital's] problems and give us a chance, to talk with them and hope that they had some influence over their own people." From the Councillors' point of view, however, it provided the opportunity to voice their disapproval of the "hospital

Diagram D

Reaction of Council to External Medical Pressure, 1950-1966


Pre-1950
1950
Pressures for Change
1956
Verbal Rejection
1962
Organization for Opposition
1964
Failure of Opposition
1966
Accommodation
Political Level
(1) Hospital Committee
(2) Insurance Scheme
(3) Survey
(1) March Hearing
(2) Complaints Committee
few complaints
(3) Ottawa Delegation
failure
(1) Board of Health
Civic Level
Health Committee
Six Nations Community Project

situation." For the public health personnel, it provided a means of implementing or at least instigating part of their program.

Members of the committee were drawn from the ranks of both Council and hospital; Indians and non-Indians were equally represented. Two Councillors and the Chief Councillor represented local interests, as did an elite school teacher. The hospital administrators, both medical and business and, later, a public health nurse and the Director of Nursing constituted the hospital's contingent. The elected Councillors were usually replaced every two years, but the hospital representatives were permanent members.

Meetings were held on a monthly basis except for some irregularity during the first year's meetings, but all were well attended by the members. This initial year of activity was followed by a year's hiatus, after which a more steady monthly program was arranged, including the preparation of an agenda before each meeting was held in the hospital. Only two formal offices were created by the committee: that of secretary was filled by the then secretary to the Council, and that of chairman was occupied by the business administrator of the hospital. Minutes were taken even prior to the 1958 reorganization. These briefly reported topics of "discussions." Motions were not commonly put to the floor and voted on during these meetings: this type of procedure was reserved largely for the selection of members to fill the two offices.

Throughout the four years of the committee's existence, discussions tended to centre around two types of issues: the new hospital policies and, to a lesser degree, the health and sanitation needs of the community.

Complaints about the new hospital policies and the physician's treatment of patients became more prevalent as time went on, largely turning the two-way flow of communication into a one-way attack upon the hospital. In one case, however, a physician, becoming somewhat vexed at receiving complaints, wrote his own complaint and, with his superior's sanction, forwarded it to the Hospital Committee (*see* p. 94). In response to the demanding attitude of one mother, he described the circumstances and reasons behind his apparent reluctance to offer assistance and medication.

Other complaints of the residents were directed at the limitation of out-patient evening office hours to only two evenings in the week, when the committee felt that three evenings would be more accommodating to the people. This desire was put forth in a motion seconded by the Indian Agent, but it apparently never reached the hospital administration representatives, who were perhaps absent that evening. Several meetings were devoted to the issue of compulsory hospital insurance, and its administration and applicability to special situations. The desirability or undesirability of this insurance scheme was never mentioned in the Minutes; however, the Council's stand on this issue was already public knowledge.

The second type of issue treated by the Hospital Committee focused on certain perceived health needs of the community. A church, for example, was requested to allow use of its facilities for a monthly Well Baby Clinic, and this request was later formally enacted by the Council. Other community improvements met with less approval. An annual garbage collection, suggested by a public health nurse, was put forth to Council but was not passed, largely because it required financial support. Another such topic was the building of a public well along the river road. This issue, though repeatedly raised in Council over the years, both formally and informally, still has not become a reality, and probably never will if the proposed water system for the village is built.

Despite the fact that communication became somewhat constricted between the Council and the hospital, the committee did act as a safety valve, and some tension was relieved through the airing of complaints, which, according to one minister, were "both unfounded and genuine." The hospital administrators tried to present reasons for existing policies and, spurred on by some interest in Council, even discussed with that body the operating costs of the hospital. But although these reasons for existing policies may have been understood on a practical basis by the Council and the people, they were, at the ideal level, overridden by even stronger feelings that, as one Councillor phrased it, "the government owes us free medical services" and "should treat us like human beings."

The ultimate aim of both parties involved was that of mutual persuasion, for the "other side" to see "our side." Aside from this cathartic function, the committee was unable to fulfil the anticipations of either the Council or the hospital. The Council wanted hospital policies changed, not justified, by the hospital administrators, who were not the policy formulators. The optimistic hope of the hospital administrators that this justification would receive even partial acceptance and be disseminated to the people through the politicians was soon dissolved. Rejection, not acceptance, was the response of the Council, and this attitude was transmitted to the people when the politicians were approached for advice regarding payment of hospital accounts.

In the committee meetings there was, however, a noticeable increase in concern with and promotion of expanded health facilities on the reserve. These ideas, which originated not from the Councillors but from the professional medical personnel, largely public health nurses, were successful in gaining Council approval only if the expenditure of band funds was not involved. It was not until the elite began to take part in the discussions that such ideas were actively fought for by the non-conservatives, and this began with the forming of the Health Committee early in 1960. At this point the Hospital Committee's title was replaced by that of "Health Committee," but this was only one indication of the changing orientation.

This 1956 to 1961 period of rejection of proposed changes was inaugurated by the debate over hospital insurance, which occupied much time in Hospital Committee meetings. In 1958 the Council announced a decision of non-agreement with the Federal Government's proposal, which set the tone of ensuing dealings with the Department of National Health and Welfare. Finally came the Council's denial of cooperation with the survey of the reserve required to assess eligibility for government coverage of hospital insurance. Shortly after this decision came the "revolution," which further strained relations between some Six Nations and the

Indian administration. This five-year period, in summary, witnessed the formulation of the Council's stand on medical issues and its attempts to negotiate these issues through the Hospital Committee. No formal groups were organized entirely for the purposes of opposition, as occurred in the following two years. It was because of the failure of negotiations to produce alterations in the new policies that more determined action was later taken by the Council.

The March hearing, 1962

As dissatisfaction mounted over the new programs, complaints about treatment by physicians at the hospital began to be put to Council, largely by non-conservatives. This indeed was the apex of the hostility toward the changing physician's role and the particular incumbents of this role.

Angered at an incident at the hospital involving his own child, the then Welfare Officer gathered several complaints, including his own and a relative's, and presented them to Council, requesting that urgent attention be given them for the welfare of the Six Nations as a whole. Shortly after this request was made to Council the following article appeared in a local newspaper.

> Six Nations Indians Demanding Probe of Medical Care; Reserve Residents Tell Councillors Care Inadequate
>
> OHSWEKEN — An investigation into medical care received by Indians at the Lady Willingdon Hospital here is being sought by the elected council of the Six Nations Indians.
>
> Written complaints, which were read at Thursday night's council meeting, concerning doctors at the hospital, spurred the council to action. Members will meet with Dr. J.A.C., MP for Brant-Haldimand, on Saturday.
>
> Council members will demand that Dr. J.C. take the written complaints to the Department of National Health and Welfare in Ottawa and ask for an immediate investigation.
>
> "We've heard verbal complaints about the hospital for years," Chief Councillor G.V. said, "but this is the first time we've ever received written complaints. I feel it's time for action."
>
> An attempt was made to have the complaints about the hospital's three doctors . . . tabled until hospital authorities could be present. The motion was defeated.
>
> Mr. V. said he had asked hospital officials to attend the meeting.
>
> "I received a letter saying Dr. C. [resident physician] had a previous engagement but would be pleased to meet with us at a later date at the hospital," Mr. V. said. "I then called Mr. H., assistant hospital administrator, and he refused to attend this meeting.

"They won't even come and meet with us here. I'll never go down there for a meeting."

Councillor F.H. said it would be useless to attend a meeting at the hospital.

"You won't get any place down there," he said. "If you want action you have to go to the members of Parliament."

Mr. H. said a thorough investigation should be conducted.

"They treated me for flu when I had typhoid fever," he said. "They insisted I had flu but when I didn't get better I went to a Brantford doctor and he said I had typhoid fever and slapped me into hospital."

Mrs G.J., a woman councillor, suggested a check be made to find out what qualifications the doctors hold.

H.S., welfare administrator on the reserve, said he thought his baby girl might have died had he followed instructions given his wife by a reserve doctor. Mr. S. said his wife took the child to a doctor last Saturday and the doctor told her the baby had a congested chest cold. The reserve doctor suggested a treatment and told Mrs. S. to return with the child in three days.

"I wasn't satisfied," Mr. S. said. "I called a doctor in Brantford and he said my little girl was suffering from bronchial pneumonia. She's been in Brantford General Hospital since Saturday."

Three letters read to council followed a similar line.

H.T. wrote that a reservation doctor told him a cut in his daughter's leg wasn't serious. The leg swelled considerably, he said, but the doctor insisted there was nothing to worry about.

A Brantford doctor treated the girl for blood poisoning.

Mrs. V.J. said officials at Lady Willingdon Hospital told her that her daughter was suffering from a congested throat. It turned out the little girl had tubercular meningitis. She had been confined to the Hamilton Sanitorium since last October, the mother stated.

Mrs. R.S. wrote: "I watched my infant son fail before my eyes." She said one of the reserve hospital doctors insisted the boy was not seriously ill.

After two months she took the baby to a Brantford physician, who diagnosed the illness as tetany, a disease which creates spasms which weaken the body (*Brantford Expositor*, Feb. 9, 1962).

Following the inability of one physician to appear at Council to discuss the complaints, a senior administrator of the Indian Health Services was asked to visit the reserve and discuss the matter with the Councillors in their chambers. The senior officer complied with their invitation but, because of the confidential nature of personal medical experiences to be discussed, the meeting was held, to the Councillors' vexation, at the hospital.

This hearing, not open to the public, brought together those with complaints, the Councillors, the hospital physicians, and the hospital administrator. The meeting was presided over by an officer from the Department of National Health and Welfare. Complaints were voiced, and the physicians were called upon to explain their treatment of each case. This calling to task of the physicians was an instance of unusual licence in lay relations with the medical profession, but one which the Council felt was rightly due them and the people. A few days after the meeting the following article appeared in the same local paper.

Release No Details on Indian Hospital Meeting

OHSWEKEN (Staff) — Chief Councillor G.V. refused to comment today on a five-hour meeting held behind closed doors at Lady Willingdon Hospital here Wednesday night.

Members of Six Nations Indian council met with hospital authorities and Dr. J.H.W. of the Department of National Health and Welfare, to discuss alleged "poor medical care" received by Indians at the hospital. Council requested the meeting after hearing a series of complaints about the hospital and its doctors.

"I have nothing to say," Mr. V. said this morning. "Council will make a full report at its next meeting."

Other members of council also refused to comment on the meeting. But councillor Mrs. R.H. said: "No one has to worry—we are not going to let our people down."

The chief councillor attended the five-hour session at the hospital despite the fact he told

> members of council last month: "I'll never go down there for a meeting."
>
> Mr. C.H., assistant hospital administrator, explained the meeting was held in private because, "it is against doctors' code of ethics to discuss patients' illnesses."
>
> . . . Mr. H. said "I refuse to make any statement on the outcome of this meeting.... But I do want to make it clear that patients here receive the best medical care available."
>
> The three doctors at the hospital . . . are fully qualified general practitioners, he said. All three doctors received medical degrees overseas, and, since coming to Canada, they have served a one-year internship and have written medical examinations.
>
> Mr. H. admitted that facilities at the hospital here are limited. However, if a patient requires special attention, the doctors do not hesitate to send the patient elsewhere, he said.
>
> Indians on the reservation receive free medical care at the hospital here. Patients sent to other hospitals by doctors here have all expenses paid. But, if a patient seeks medical care elsewhere on his own, he has to pay his way, Mr. H. said.
>
> "You have heard one side of the story and I think you should hear the other," Mr. H. said. "However, the doctors will not issue a public statement" (*Brantford Expositor*, March 8, (1962).

The decision reached at the meeting by the presiding senior medical administrator, that there was no evidence of malpractice, did not rest easily with the Council; nor does it now among some Council members.

This confrontation, which received much publicity in local newspapers, drew mixed reactions from the non-conservatives. The Councillors, believing the complaints justified, felt that the Federal Government had once more "smoothed over" a crisis without critically assessing it and correcting or even acknowledging injustices. Most of the elite, however, felt that, although the treatment received from physicians at the hospital was not the optimum and although there were some grounds for complaint, these particular grievances were "foolish" and reflected a lack of sophistication in some complainants. This confrontation was for many elite a source of public embarrassment, and at best a futile effort with suspect motivation. As for the lower status, although some were much more cognizant of the "showdown" than others, most demonstrated little concern about the outcome.

Despite the failure of this hearing to produce a satisfying assessment of the physician's role performance, the Council continued its attempts to maintain channels of communication with the hospital to review continuing grievances.

The Complaints Committee

A month after the "showdown," the Council appointed a committee of two men and the Chief to carry worthy complaints to the physicians and the hospital administrator. In many ways this was a continuation of the later pattern of the Hospital Committee and brought equally unrewarding results, because many of the desired changes were impossible and inconsistent with the modern practice of medicine. The limitation of house calls to "emergencies," the operation of the hospital (as one Councillor phrased it) "like a factory, opening at nine and closing at five" to the public patients, the fact that "medication takes too long" and that diagnosis was "too slow"—these were all sources of fault finding. Physicians' attitudes towards patients, their alleged impatience and "calling down" of individuals were of concern too, but this lay in the realm of interpersonal relations, not of formal policy.

Complaints continued to come to the attention of the Council during the following year. To add to this continuing source of discontent came increasing numbers of notices from the Federal Government that economically independent families were to pay their own hospital premiums if they were to remain insured. Both these issues culminated in the appointment of a delegation of the Complaints Committee and a few other Councillors to state their case to the Minister of National Health and Welfare in Ottawa. Specifically, they wanted the removal of a physician and the extension of government-paid premiums to Council-paid employees. Because of underlying opposing viewpoints on these issues between the Federal Government and the Council, and because of uncongenial interpersonal relations between the spokesman and the Minister, neither request was complied with.

The lack of success of all three endeavours between 1962 and 1963 resulted in a decline of activity. Complaints decreased in number after 1963, but the committee was still reappointed each year until 1966, when its title was changed to the "Board of Health" at the suggestion of a new hospital administrator. Formal channels for communication between Council and hospital have been maintained.

Efforts to correct sanitation deficiencies had their ultimate origin in the Federal Government. The Health Committee developed from a "Sanitation Workshop" held on the reserve in late 1959 for representatives from all southern Ontario reserves. Attending this workshop from the Six Nations Reserve were two higher status women (one an elite; both members of the Women's Institutes). The main topics of interest at the discussion session were adequacy and safety of water supply, garbage disposal, and the disposal of human wastes; all were considered vital to the representatives' reserves. The Workshop, as defined in the booklet given the delegates, was to stimulate interest in local sanitation conditions, to develop an awareness of certain inadequacies in sanitation, and eventually, when programs of change were to be embarked upon, to assist them in formulating a "plan of action." It was this issue of implementation of change in their own communities that most concerned the delegates and consequently absorbed most of the time spent in small group discussions. Not unexpectedly, from the Six Nation delegates' point of view, it was this very point of execution that was to pose a problem for the Health Committee.

In February of 1960 the Hospital Committee willingly dissolved to make way for the Health Committee. Monthly meetings were conducted by a chairman, one of the women who had attended the Workshop, and minutes were recorded by a secretary. At later intervals after the initial formation, the offices of corresponding secretary and treasurer were added; these lasted only a year, at the end of which time the single office of secretary-treasurer was created. All formal offices were occupied by non-conservative Six Nations people.

Monthly meetings were held at the hospital very regularly and were well attended during the first three years. Originally it was planned to have representatives from the various voluntary associations and professions (physicians, teachers, and public health nurses) attend: the latter to function as resource personnel, and the former as mechanisms by which information and programs could be carried to the wider community. But two different attempts to contact these voluntary associations requesting their support did not produce expanded membership. Usual attendance included the committee's officers, and representatives from the hospital, the Council, the Women's Institutes, and the ministerial association. Although still another attempt was made to contact what were thought to be potentially interested parties, even this failed. No Longhouse representatives were participants, despite the fact that a few were informed by letter of the committee's existence and aims and were invited to join. The whites who did attend these meetings as official representatives did not have a vote on motions raised during the proceedings.

The committee was most enthusiastic about implementing changes on the reserve during the first two years of its operation. Drinking water supply and garbage disposal were pinpointed as the two most critical issues to be dealt with. Soon after the committee formed, the testing of well water was undertaken by selected members of the group. Although the samples were "slow to come in" (to the hospital), the testing was completed, the results of which indicated that many wells contained "unsafe" water. A physician from the hospital undertook a water-testing survey, and the earlier procedure of the committee was repeated twice before the village's well-sampling program began in the fall of 1964 in preparation for a project to establish a water system for the village of Ohsweken. Public health nurses also advocated well-testing to the mothers they visited on their daily rounds. Through informal friendship and kinship ties, this need was communicated to others not directly contacted by sanitation personnel, until today most higher status families have had their wells tested at least once. This testing, however, is seldom carried out on a regular yearly basis.

Garbage disposal, the second crucial concern, likewise received immediate attention by the committee. As the Hospital Committee had attempted earlier, the chairman of the Health Committee put the idea of a garbage collection to the Council and after some debate finally received its approval and the necessary funds for a once yearly garbage collection (held in the spring). It was decided that the refuse was to be disposed of on the reserve in a sanitary landfill method, and the location then chosen has been used for subsequent disposals. A proposal to establish both a spring and fall collection was put forth at the committee level, but it was never implemented. It was not carried to Council possibly because of the remembered difficulty in obtaining approval for even one collection.

Although the disrepair of many privies was a matter of concern to the Health Committee, no attempt was made to remedy these faults. As with many other issues, the difficulties of financing, not to mention the convincing needed to stimulate action, inhibited committee attempts. Even so, public washrooms were repeatedly advocated for service stations and restaurants on the reserve. These suggestions met with opposition from the Council; however, the pressure did lead to the building of public washrooms in the village, an undertaking that would not bring the unpopularity that might come (and was feared would come) from restaurant and gas station owners if the issue had been pressed.

Restaurants and grocery stores were repeatedly inspected by a joint delegation of Health Committee members and physicians, and the owners were informed of unsanitary conditions whenever they existed. But the lack of any sanitation code in bylaw form, frustrating to the elite committee members, prevented the enforcement of recommendations for improvement.

Cleanliness in homes was felt to be a value worth promoting, but a way to transmit this need to those seen to be erring was difficult to find. It was suggested that individuals known to have unclean houses be called into the meetings at which the value of cleanliness would be discussed. This idea did not find general support among the members, but two committee officers did volunteer to visit such homes and talk with the women. Although this issue was then dropped and was not brought up again, the desire to communicate the connection between unclean surroundings and ill health was a continuous source of concern. "Clean-up Week," instituted by the Hospital Committee at the suggestion of public health personnel, was observed officially each spring, but such a program hardly met the requirements of the committee for year-round attention.

Inspections were also made of the food-handling concessions at the Fall Fair, and it was found that some booths were definitely unsanitary. But again, without a code or bylaw, recommendations for change could not be imposed on the food handlers. The well water at the fair grounds was tested annually before the Fair and purified as the need existed. At a later date, and with the assistance of public health personnel, a list of procedures for safe food-handling was posted in the community dining hall. Finally, during the first two years of the committee's operation, a display was made for the exhibition hall at the Fair, stressing the danger to health of insects and impure water supplies. This practice was discontinued, however, because the public health personnel who undertook to set up the display felt that they had received little support and cooperation from committee members.

By 1964 the enthusiasm, so marked in the initial stages of the committee's operation, had dwindled, largely because of its inability to interest other individuals to join and of the difficulty of implementing sanitation changes. Water testing was carried out, but it was time-consuming to survey the wells throughout the reserve. The existence of many unstable and inadequately constructed privies was well known to the committee members, as was the similar condition of many wells. But the inability "to reach the people we should," as one chairman phrased it, and to convince them of the need for such changes, severely limited the impact of the committee upon the community. The persons on whom the committee ideals had the most impact were the elite and the higher status individuals, who had, for the most part, incorporated these sanitation procedures into their daily lives years before. The lower status families, furthermore, did not always have the money to buy materials nor the knowledge to build privies correctly, to say nothing of wells.

Assistance for such undertakings is obtainable, however, if individuals are so motivated. A certain quantity of well tiles is available free of charge from the Council each year. These are allotted upon request equally among the families in the six voting districts, but in some cases the tiles are picked up by the families and not used. As for privies, building supplies *per se* are available from the Federal Government and are allocated by the Council, but they are usually requested for additions to houses or new housing, seldom for privies. It is even more surprising that despite the Federal Government's advocation of adequate facilities for the disposal of human wastes, the materials for welfare houses do not include supplies for privies.

The committee members' attitude toward their endeavours was one of discouragement. Pride was taken in the water sampling programs and the annual garbage collection, but there was a strong feeling that these innovations were not carried to the extent needed to produce the desired quantitative changes in behaviour. The garbage collection was considered far from adequate. The unsuccessful attempts to convince the Council of the necessity for better sanitary conditions in some restaurants and grocery stores proved disheartening.

This general tone of failure led to a very dejected membership. Attendance diminished steadily during 1964 and 1965, and the Council withdrew its representatives, largely as a retaliatory measure because of the discord arising over the proposed water system for the village. Successors for the offices were apparently impossible to find. Reasons for this decline were many, including, among other things, the scanty prestige the committee had (particularly with the Council) and the fact that the elite were and still are committed to other voluntary organizations, which absorb much of their time. As one chairman put it, "They're involved in so many other things. They don't come to the meetings. The last meeting I called, only one [Indian] showed up. Something's wrong somewhere." That "they don't like to have anything to do with the hospital" was another consideration, as was the fact that "the Council won't cooperate."

Since 1964 the few meetings that have taken place were prompted entirely by previously made obligations to the community, such as the garbage collection and the inspection of booths at the Fall Fair. And even this last event has not been an occasion to convene a meeting for the past two years. The committee is now essentially defunct, but its one main aim, that of establishing a safer water supply, has been carried on by the formation of the Six Nations Community Project (SNCP) in 1964.

At a special meeting of the Health Committee in early August of 1964, the development of a village water system was proposed by the Indian Agent. The idea was enthusiastically received by the committee members, who had long been convinced of the danger and the inadequacy of the water supply on the reserve and, in particular, in the village. In order to obtain evidence that village well water was indeed unsafe, several members volunteered to collect samples for testing, and at the same time to ask the villagers their opinions on establishing a centralized water system. The thirty-six samples taken only reinforced the desirability of a safe water supply.

The villagers, who were generally in favour of a community water system, were subsequently notified of a forthcoming meeting of villagers to discuss the issue. A month later a meeting was held in the community hall when, according to the minutes, the Indian Agent "stressed the need for water and also spoke about the sanitation in the village being a grave problem." He then "gave the members advice on how to form a committee and the different channels they would have to go through in order to make this a successful project." Three officers were then elected: a chairman, a secretary, and a treasurer—all were of higher status, but only the second position was filled by an elite. The office of treasurer was occupied by a Councillor who had been active for some years on the Health Committee, and the chairmanship was held by a retired school teacher, chosen because of her educational qualifications and apparently because she had the free time to devote to such a campaign.

During this meeting the Indian

Agent drew to the attention of the villagers the fact that a southern Ontario reserve had already established a centralized water system, and that inquiries into their method of procuring this system might prove valuable as a guide. His well-received suggestion subsequently resulted in a delegation being sent to that reserve to inquire specifically about the method of water purification and the means of financing the project.

On administrative advice, "resource personnel" were drawn into the project during this early stage. A local Public Utilities Commission representative, addressing a meeting, informed the villagers of the different possible sources from which water might be obtained and stressed the need for consulting engineers to assess the technical implications of the project. The necessary professional personnel were obtained through the Federal Government, and a tentative estimate of $70,000 was suggested as the cost of a water control and purification plant. Eventually the maintenance of such a plant would be financed by billing residents for use of the water.

Before the group was informed of the possible cost of such an undertaking, the secretary had sent a letter to the Council requesting recognition of their group and its aims. The request was denied because of an anticipated financial commitment, which the Council felt it would be unprepared and unable to make. Of the approximate $125,000 annual revenue of the band, which is scarcely sufficient to meet the expanding operating costs and new demands, a $70,000 commitment would reduce the fund to less than half. When the estimated cost of the project became known to the Council, this even further solidified its decision; despite a willingness on the part of the leaders of the project to attempt to raise some funds through a "draw" and other proposed means in the future, the issue of financing loomed large.

At one point in the proceedings it was learned that a loan of $40,000 might be obtainable from the Federal Government, leaving $30,000 to be raised by the villagers. If each of the estimated one hundred families in and near the village were to pay $300 toward the installment of a plant, such a financial objective could be met. Although some villagers were in a position to pay this amount and would have done so eagerly to obtain a satisfactory water supply, there were others known to be either unable or, possibly, unwilling. Thus even the prospect of such a loan did not solve the financial question. Nor did the visit to the reserve where such a plant was in operation give any guide-lines for this problem. That particular water system had been financed through federal assistance and band funds, substantially augmented each year by revenue obtained through renting land to a distillery.

In mid-autumn of 1964 the Council's position on the campaign had become quite evident, not only in the denial of authorization of the project's aim, but also in the refusal to allow project meetings in either the Council House or the dining hall at the fair grounds. A third request to use public school facilities was also denied the group. Determined to carry out their project's aims, they finally held meetings in the two restaurants in the village, the owners of which strongly supported the water system.

At one of these meetings the Councillors were asked to attend (only two complied with the invitation), and an attempt was made to convince the politicians of the need for such a system. Here, as in earlier discussions, political considerations as well as sectional reserve interests played more than a minor role. Political suicide was phrased in such terms as "What would my voters think if I supported this thing?" when, in this case, voters would be non-village residents. From the non-villagers' point of view this was phrased in terms of "Why should my band funds go to the village?" The main counter-argument, that such a water system would "benefit the entire reserve" because the senior public school would use such a system and because residents without wells could come to the village and obtain water, had little effect in swaying the opposition.

While these political and sectional interests did account for part of the opposition, an equally significant aspect of this resistance lay in the fact that the project leaders apparently did not pay deference to the political body before they had organized a functioning group. During one particular encounter with the Council, the chairman was said to have given the Councillors "a real calling down" for their reluctance to sanction the committee's aims. This chairman, claimed by many to be "a real strong Mohawk Worker," was not successful in her aggressive interpersonal relations in gaining Council's support. In the concluding analysis, this lack of deference will be seen to have been a signal factor in the discord between the Health Committee and the Council; in both cases it produced similar results, a decline of the sanitation committee's activities.

The net effect of the Council's refusal to endorse the project was the stagnation of the campaign. Meetings were held in abeyance for over a year until a "new Council" was elected in the hope that "fresh blood" might reduce opposition. When the project was again brought before the Council, decisions were put off until the spring, when the financial picture could be presented by the Indian Agent. This allowed the Agent time to explore any possibilities of monetary support from the Indian Affairs Branch. Council position on the project during this time was noncommital.

It appears that a water system will eventually be built, in conjunction with a housing subdivision scheme, currently under discussion by the Council. The project's formal organization has disintegrated, but the members' anticipation that "new blood" might "swing things" in Council was not incorrect. A new Councillor with particular prestige because of his professional background is presently chairman of a recently formed sub-committee, which will, in future, be responsible for handling the proposed town-planning program.

When the overall picture of medical affairs at the community level is viewed, it becomes evident that a division of labour, so to speak, existed among the non-conservatives in their efforts to cope with external pressures to change the medical set-up. This division occurred along pre-existing status and power lines in the non-conservative "community"; the response to pressures for change did not create this division, although it undoubtedly intensified it. Not unexpectedly, participants in this community action did not represent to any great extent the lower status. The power alignments took place among higher status individuals and operated on two axes: political and civic (i.e., comprised of the elite). Those in politics ultimately held the upper hand regarding financial power, as it was the Council alone that had authority to allocate the band funds repeatedly required to carry out civic-sponsored sanitation programs.

Political activity at the community level

The Council's participation in medical affairs was, as presented above, entirely limited to combating direct pressures to change medical administration on the reserve. As the Council rather unrealistically attributed these changes mainly to the Federal Government, when in fact they were largely due to a transformation of the medical profession and complex itself, its relations with both the local hospital and the federal health department because very strained. Changes in medical practice were seen to cause unwarranted hardship and in some cases even death, a matter of no little consequence.

Opposition in the form of delegations and committees followed a formal pattern, one that had long been resorted to by the Six Nations. When it finally became apparent that the Federal Government's new programs of medical financing and medical practice could not be halted, a general attitude of resignation spread among the Councillors. That their fight was not altogether unjustified, however, became evident in late 1965 during an inquest into the death of an Indian patient en route from the reserve hospital to a local city hospital in the "ambulance." According to a local newspaper, and much to the satisfaction of many Six Nations, the coroner's jury "recommended that a closer doctor-patient relationship be established at the Lady Willingdon Hospital in Ohsweken."

In assessing whether the Council's endeavour is indicative of the general attitude of the Six Nations towards medical treatment and hospital insurance, there is one consideration of particular importance. Despite the opposition to administrative changes, there was actually no decrease in the use of hospital facilities, which fact possibly attests to the Six Nations' dependence upon Western medicine, in spite of its form of presentation. This is apparent from the hospital's attendance figures for a thirteen-year period, which are presented in Table 10. Although all the annual reports covering this period are not available at the hospital, those that are indicate a sustained use of its facilities. In 1952, for example, and prior to the period of intense opposition and even verbal rejection of new policies, 9,380 out-patient visits were made to the hospital, and 743 persons were admitted. Ten years later, at the height of the Council's measures to alter the new hospital practices, 10,553 out-patient visits were made. In the same year 1,144 persons were admitted as in-patients. By 1964, hospital use was about the same: 9,951 out-patient visits were made, and 805 patients were admitted. That the total number of persons using the out-patient department's services was little affected by the crisis is evident when the figures from 1959, 1962, and 1963 are compared. In 1959, 2,431 persons used these facilities; in 1962, at the aftermath of the "showdown" 3,470 persons made visits; and in 1963, 2,887 persons made out-patient visits. Thus 50 per cent of the estimated resident population for 1963 utilized the out-patient facilities, and an even larger percentage made demands upon these services the previous year. Although the resident population is at present probably slightly higher than it was during the early 1950's, this does not invalidate the conclusion that the hospital is as much in demand now as it was both before and during the period of disruption.

In future, however, in-patient use of the facilities will be expected to decrease because of the desirability of redirecting confined patients where more extensive medical equipment is available. This off-reserve confinement will apply equally to maternity cases, and an apparent trend in this direction is already noticeable, although figures have been collected by public health personnel for only a five-year period.

Table 10

Annual Hospital Attendance, 1941-1961

Year	Out-Patient Visits	Out-Patients	Admissions[1]
1941	—[2]	—	357
1942	—	—	—
1943	6942	—	420
1944	—	—	435
1945	—	—	—
1946	—	—	538
1947	—	—	—
1948	—	—	614
1949	—	—	650
1950	—	—	492
1951	—	—	672
1952	9380	—	743
1953	11497	—	907
1954	12253	—	1121[3]
1955	9645	—	1021[3]
1956	9437	—	814
1957	8085	—	741
1958	7596	—	799
1959	8024	2431	922
1960	8246	2448	867
1961	10590	2813	891
1962	10553	3470	1144[3]
1963	10821	2887	972
1964	9951	—	805
1965	9808	—	733
1966	10204	—	746

[1] Includes adults and children, but not the newborn

[2] Figures not available

[3] The greater number of admissions during these years can probably be accounted for by frequent admissions and readmissions of Eskimo infants. These children were usually treated at the Sick Children's Hospital in Toronto and then transferred to the reserve hospital for the period of recovery

In 1961, for instance, 27 per cent of the births in families resident on the reserve occurred in hospitals outside the reserve, particularly in Brantford and Hagersville (*see* Table 11); in 1964 the percentage rose to 41 per cent, and in 1965 to 38 per cent. The most significant increase, that between 1963 and 1964, is in all probability explained by the acquisition of hospital insurance by a greater number of Six Nations families.

Table 11

Locations of Births in Resident Six Nations Families, 1961-1965

		Reserve	Elsewhere	
Year	Total No.	Hospital	N	%
1961	166	122	44	27
1962	180	132	48	27
1963	170	126	44	26
1964	186	110	76	41
1965	130	80	50	38

This tendency to utilize outside hospitals for delivery is due partly to the advent of hospital insurance and partly to the attitudes of most women towards medical care. Greater concern is demonstrated over infant and child health than that of the mother, or of adults in general. The belief that care might or would be superior to that obtainable at the reserve hospital has led mothers to go elsewhere. And, too, the fact that anaesthesia is used sparingly by the physicians during delivery (and preferably not at all because of the lack of a trained anaesthesiologist) is unpopular with many women. Another factor is the reserve hospital policy of placing the infant in a bassinet beside the mother's bed, which frequently results in less sleep for all mothers in the ward.

Thus by the many direct pressures to obtain health insurance from both government and employment sources, and inadvertently through the maintenance of unpopular hospital policies, the Federal Government's aim of deterring the economically viable families from dependence on the Indian Health Services has begun to be partly realized. Approximately 50 per cent of hospitalization premiums are being paid by residents themselves. But this relocation of the source of medical care away from the reserve will continue to be a slow process as long as there remains any opportunity of gaining medical assistance free of charge, a circumstance which includes, of course, the fact that "the government can't make you pay" for services received.

Prepaid health insurance schemes have made possible an important element of choice in selecting a hospital and, to a lesser extent, a private physician. As one informant said, "We have hospitalization; why not go where we want." Previously no such alternatives on an equal financial basis existed. For the indigent element the situation will probably remain largely unchanged, since they are required to utilize the reserve hospital because they are insured by the Federal Government.

Although there are some signs that the Six Nations are beginning to turn to outside medical sources, this has not occurred on a scale that one might expect from the heated dissatisfaction aroused over the "hospital situation." Hospital attendance has undoubtedly been maintained at about the same rate because medical services have been essentially "free" to the patients; they are close by, and are given largely within an Indian setting. There was certainly a general antipathy to medical administration, but it is questionable whether this antipathy was as widespread and severe as the Council felt it to be. It would seem that the strong dissatisfaction expressed by the few dissenting voices was not felt by most people and was not intense enough to overcome financial considerations.

Civic leaders (that is, the elite) did not involve themselves in the friction between Council and Federal Government. As mentioned previously, they felt that medical services lacked the humanitarian touch and the desirable efficiency, but they held the attitude that nurturing grievances and "bucking the government" was and is a futile waste of time. On the whole, they strongly prefer to remain outside the political arena and to contribute to the community in ways that will promote change.

After 1950 the elite did, in fact, react to government programs directed to alter the medical affairs of the reserve. But unlike the political leaders, the civic leaders were in accord with the suggested changes. The idea that measures were needed to improve sanitation conditions fell upon highly receptive ears, and the individuals involved, skilled in civic affairs, organized and maintained independent committees by means of which their goals could be achieved.

That their goals were not achieved to their satisfaction was a result not only of the difficulty of the problems, but also of several interrelated social factors.

The most fundamental aspect of this problem of implementing change lay in the existence of two different prestige groups among the higher status families and of two different methods of community contribution. One is that established by the elite, who join several of the voluntary interest groups on the reserve and who believe that community service should be without financial reward. The other method is undertaken by the politicians, individuals who achieve political power by being elected to the band Council. These two types of contribution, as mentioned earlier, represent two almost mutually exclusive ways of obtaining social recognition and prestige within the community. The politicians as a group, despite the degree of political power they hold, have less prestige than the elite, who have usually received more formal schooling and who hold professional or clerical white collar jobs. Of the individual Councillors in the past two Councils, only one has had professional standing, and none has had white collar jobs. With very few exceptions the policiticans do not participate in the interest groups, excluding the churches, which have long been established on the reserve. Of the present Council only one man belongs to the Ploughmen's Association and the Agricultural Society, and he is very active in the Board of Directors of the former organization. One other Councillor has been involved occasionally with these two organizations. Of the few women Councillors, none is involved in the Women's Institutes or the Agricultural Society, although one has been sporadically interested in the past. Nor are the numerous sub-committee meetings that absorb much of the politicians' time a factor in their nonparticipation in civic interest groups: prior to becoming Councillors, most of these individuals were not active in the groups.

Second, and of no little significance, is the fact that the elite strongly foster the ideal that changes are needed on the reserve (i.e., a recreational program for teenagers, a library, a kindergarten program, a "fine arts" association, and improved sanitation). Although very few would go so far as to suggest that the Indian Act be abrogated to allow greater facility in obtaining loans by using land and buildings as collateral, many are adverse to the Federal Government's housing program in which seemingly only those subsisting on low incomes are given the opportunity to improve or build new houses with economic assistance. They strongly feel that those with higher incomes and those who "try" should be given equal opportunity. Hence the elite are the sponsors of culture change, but always within the context of maintaining the reserve system, which, as part of the Indian Act, inevitably hampers economic progress, particularly where farming is concerned. The fear of increasing white authority on the reserve (which might be a factor in the establishment of a water system for the village because of financial aid) although not unconsidered in the campaign, is seldom intense enough to inhibit the promotion of change. In contrast to the elite, the politicians tend to promote the status quo and act as the guardians of Indian rights. Not unrealistically, they fear that these rights may suffer if too many innovations are established that are dependent upon grants with jurisdictional authority involved.

A third factor in this attempt by the elite to introduce change is the social distance between the two groups aspiring to contribute to the community. The elite represent an entirely higher status background, whereas the politicians hold both non-elite higher status and a few lower status positions on the socioeconomic continuum. This social distance is very pertinent to the recognition of both sanitation committees by the Council. With the exception of the overlap between the elite and the Council in the form of one person (which was of short duration), and a few Councillors who might be said to hold "fringe" elite positions, informal friendship and kinship ties between the civic and political leaders are neither close nor frequently activated. This, of course, does not imply that interpersonal antipathy characterizes their relationship. But the respective interests and views on community action of the members of each group bring the participants to two separate foci of organization and absorb much of their time both during and between formal meetings. Consequently, outside the formal arena of group activity, the issues of sanitation are not discussed on a person-to-person basis in a conciliatory manner in which the prestige of the two groups is not at stake. On the whole, the exchange of ideas takes place within a formal context marked by rather unsatisfactory communication between the sanitation committee(s) and the Council, where power and prestige become competitive and where interaction is in terms of the roles of elite and Councillor.

Communication between civic and political leaders and the groups they form has been sporadic at best, mainly because the sanitation committees desire the autonomy in their operations that is allowed the other interest groups. Furthermore, the feedback to the Council from its representatives on the committees is not usually the most reliable, a circumstance which in itself is not peculiar to this situation. Although Minutes of all meetings were to be forwarded to the Council, this in fact was not consistently practised. As a result, the Council, which expected to be deferred to by being informed of committee proceedings, did not always receive this deference and tended to retaliate by denying its approval. This reluctance to give authorization was a dominant reason for the increasing disenchantment among the members of the two sanitation committees and for the discontinuation of the Health Committee.

Another issue in this power play to introduce sanitation changes stems from discordant beliefs as to which body should be responsible for sanitation and medical affairs on the reserve. The politicians allocate this duty largely to the Federal Government, as they did in 1958 regarding the highly charged issue of Ontario Hospital Insurance. The elite hold an opposing viewpoint. They claim that measures for sanitation should be promoted and acted upon by the local Council. The elite interpret their function regarding sanitation as an obligation to the community that must be met if the Council does not see fit or is not able to do so. And when the Council did not see fit, the elite operated on their own terms, which resulted in strained relations with the politicians. Underlying the perspective of the elite is their assessment that these sanitation changes are urgent and vital; whereas the Council, although not denying that improvements can be made, does not single out this area as paramount. The approach of the elite, to repeat, undoubtedly is a product of their employment *on* the reserve in the areas of medicine, education, and school maintenance, where sanitation and health issues are naturally brought to the fore in their daily work.

The final issue involved in sanitation changes is the financial one. Because of the relatively stationary annual budget and the increasing cost of maintaining services already existing on the reserve (predominantly roads and welfare services), it is not unexpected that the Councillors should be reluctant to undertake extra financial obligations. This was the case not only with the annual garbage collection, but with the village water system to a greater degree. As taxation of any description as a means of increasing band revenues is ruled out by the Council and many residents, additional expenses are carefully scrutinized. Funds for such programs ultimately stem from federal and provincial grants so the possibility of "the white man taking over our reserve," as one informant phrased it, is an issue of serious import.

The ability of the elite to effect sanitation changes can now be understood in terms of the separation of those who have felt the urgency for change but hold no formal political power and of those who have the political and public financial power to sanction change but do not feel the need to be pressing. Phrased in other terms, it represents the confrontation of those who are actively acculturating with those who are passively acculturating, or even resisting culture change. The innovators (i.e., the elite) approached the promotion of sanitation goals in a determined frame of mind and with a desire for the autonomy that their interest groups customarily enjoyed. They formed committees that enabled them to proceed toward their goals in an orderly fashion. But it is clear that the very existence of these committees, although a necessary method of procedure, tended to solidify on a formal basis the poor communication and discordant beliefs already existing between the elite and the politicians at an informal level. Despite the resulting barrier, the impasse thus created was not entirely impenetrable. This formalizing of operations tended to crystallize the ideas of the elite and to increase their determination to achieve their aims, before it led to disheartenment.

In summary, the role of the elite can be seen as that of instigator. Although they do not have the formal authority to effect change in sanitation arrangements at the community level to any significant degree, they have the drive to adopt new goals and envisage change. In the last analysis they exerted influence upon those who had the formal power and in some instances (i.e., garbage collection) this was enough to produce action. But in other instances, such as the questions of the village water systems and a sanitation code enforceable by the Council, this influence was insufficient. The necessary pressure ultimately emanated from local federal administrators who, from the Council's point of view, were the representatives of the bodies duly responsible for such programs. Had these administrators promoted programs of change in the absence of any community interest, it is highly probable that results would have appeared much more slowly.

In regard to the elite-Indian Agency relationship, a comment on Kluckhohn and Leighton's description of "Agency Indians" is in order. In analysing American Indian administration efforts to introduce programs of change among the Navaho, they claim that there is

> . . . the very natural tendency of the administration to deal most readily with those Indians, who—sometimes for reasons of immediate self-interest, such as getting a government job—are willing to go along with official suggestions and plans, and who will "show results." These persons then become, in the words of their neighbours, "Agency Indians" (1948:106).

In a significantly qualified form, this statement can be seen to apply to the non-conservatives' involvement in community health programs. That the Six Nations administrative officials have sought out the higher status people, particularly the elite, to participate in programs of change has undoubtedly been the result of two factors: the officials' realization that if action were to be taken, these leaders would be the most likely to undertake and sustain it; and secondly, the administrators' desires to work through, at least initially, pre-existing committees. An additional factor, moreover, was the fact that when these changes were to be put to the people, the Council, in some instances the most likely public body to approach, was intransigent in its stand against the Federal Government's determination to alter the nature of medical administration and practice on the reserve. Hence the Councillors' attitude toward the Federal Government, regardless of the particular department involved, was not conducive to their acceptance of change when their own program for change had been denied them.

That the elite were "willing to go along with official suggestions" because of hopes of federal jobs or, more generally, because of a desire to show deference to the federal officials, is highly doubtful. At that time the elite had held civil service positions for many years. Furthermore, despite their employee status with the Federal Government, they were not inclined, nor are they now, to bend to the desires of the administration when the programs lie outside their immediate responsibilities with the federal service. Nor were the elite pressured, even informally, as employees to commit themselves to these programs. Elite involvement, although initially a product of Agency drive for change, was sustained not by external motives *vis-à-vis* the Indian administration, but by a high receptivity to the ideas and by a determination to effect sanitation improvements they felt were greatly needed despite the disagreement of the Council. That they "went along with suggestions" made by Agency officials explains neither their initial enthusiasm, their "struggle" with the Council, as one chairman phrased it, nor their disheartened feelings when the projects' aims were thwarted. That Agency stimulus was apparently needed to originate the sanitation program is not denied, but that it was a major factor in the community activity that was to follow is not supported by the data.

Since the elite choose not to enter local politics because of prestige factors, employment obligations, and the status quo attitudes of the Council, and seldom even attend any Council meetings, their sphere of influence is limited to the informal, through a few ties of friendship with the politicians, and to the few concessions they are able to obtain from the Council upon formal request. Operating in their community activities, largely outside the political arena, they are usually allowed the freedom to direct their programs as they desire, without extensive Agency involvement, as must be the case with the Councillors.

Chapter VII

Conclusions

The 100-year period of medical acculturation from 1850 to 1950 was marked by increasing dependency upon Western medicine and, from the public's point of view, was one of general satisfaction with the physicians' role performance. From the Council's viewpoint, however, the years from 1900 to 1924 constituted a disruptive period, in which the Chiefs unsuccessfully attempted to control the recruitment and dismissal of physicians. Thus, although the doctor-patient relationship was relatively free of misunderstanding and discord during this century, the doctor-community relationship was extremely strained for two decades. This was not because of the lack of "sympathy" for the Indian patient attributed to the doctor, but because of the antipathetic political relationship between the Chiefs and the Federal Government.

It was during the 1950's that abrupt change came with the pressure to update the medical services on the reserve. Unlike the conservatives, who could obtain emotional support from Longhouse methods of curing, the non-conservatives were for the first time denied this personal quality in the curer's role, as the physicians became hospital-centred rather than client-centred. The subsequent crisis period cannot be interpreted as a rejection of Western medicine, but on the contrary, as behaviour explicitly indicating dependence upon it. The non-conservative reaction indicated the existence of very definite expectations, long conditioned, of the role attributes of physicians. To rephrase Gluckman (1963: 43), they were fighting to defend the physician's ideal role and the values of its office, against the physicians themselves.[1]

That they fought at all is not explainable simply in terms of Indian rights or human rights. It is explainable in terms of their high degree of acculturation to (i.e., acceptance of) the country doctor role model. The fact that this adjustment is being demanded of North Americans in general is not realized by some Six Nations, who interpret present medical affairs as the perpetrations of the Federal Government. But that they are having to adjust is evidence that the Six Nations now hold a comparable position with whites regarding medical behaviour demanded of them by the profession. In other words, they have had to change not only their expectations of the physician's role performance, but also their own role performance as patients.

The maintenance of separate medical facilities on the reserve, and restrictions up to 1950 in the use of these facilities, prevented a "validation of this aspect of acculturation" (Broom and Kitsuse 1955). The validation or testing of adopted medical traits within an inter-ethnic context is now beginning to be forced upon them, first within their own community in the form of non-Indian-raised and non-Canadian-born physicians, and secondly in the federally exerted pressures to seek medical assistance outside the reserve.

The conservatives, however, can and still do depend upon Indian medicine as well as Western medicine, and because of this "double security" they are guaranteed, potentially, emotional support from some therapeutic relationship. Since the non-conservatives entertain only a circumscribed faith in Longhouse ceremonial or herbal curative methods, this potential source of personal support and care is eliminated. That some non-conservatives did not wish to test their acculturation in medical matters was obvious for both economic and political reasons. Those who have tested it by establishing a tie with a general practitioner have experienced both satisfying and dissatisfying results. The cost factor, the reluctance of physicians to make house calls out to the reserve, and the waiting in turn for an appointment are compensated for by their freedom to choose a doctor of their personal liking, thereby experiencing the return to the therapeutic relationship of some of the personalized element unavailable at the reserve hospital.

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[1] Gluckman, in referring to the Zulu response to a "bad king" writes: "Thus the rebellion attacked the ruling king, but not the kingship itself or the claims of the royal family to it. We may indeed go further, and say that where the rebellion was against a tyrannical king, the rebels were fighting to defend the kingship, and the values of its office against the tyrant himself. Rebels were not seeking to establish a different king of political society."

It is evident that the non-conservative response to Western medicine involves a different process from that of the conservative. Although the conservative culture has undergone an additive reaction, the non-conservative "culture" has witnessed a replacement process; traditional Iroquois medicine, having little utilitarian value, has been discarded for Western medicine. Significantly, the pride in traditional herbal cures held by the non-conservatives derives predominantly from the fact that the efficacy of some of these herbs has been validated by their incorporation into modern pharmacopoeia.

Given this present dependence upon modern medicine, it is not unexpected that any perceived threat to their access to its practice should cause alarm to the non-conservatives. This threat was manifest not only in the new financial and operational policies of the hospital, but also in the adjudged lack of commitment on the part of the physicians to the welfare of the community. At the same time, the non-conservatives realize that these physicians are more highly skilled than the country doctors were. But the fact that the present doctors, in their estimation, did not optimize these skills and did not do so in a humanitarian fashion was alarming. Their desire to blend the best of two medical worlds—the emotional supportive nature of the country doctor and the technical skill of the modern physician—in their local setting and the impossibility of this selection created the dilemma. It forced a choice between going outside the local setting and sacrificing economically or staying within and sacrificing the personal aspect of the therapeutic relationship.

Since the turn of this century the Federal Government has steadily withdrawn decision-making powers affecting local medical affairs from the band Council, leaving the services to be rendered the Six Nations entirely to the discretion of the Indian administration. The trend within the Six Nations has been one of increasing dependency upon the medical complex, and their decreasing power to control access to it. Whenever the Council attempted to extend its control or prevent its current power from diminishing, a crisis arose, which tended to fuse medical matters more tightly with external political administration. Antipathy, usually characterizing both political relations with the Indian administration and individual attitudes toward this administration, tended to flow to the physicians on the reserve and reinforce already existing discontent. Indeed, medical matters have seldom been immune to the heat of political dissension.

Finally, it became evident that the prime factor responsible for the differences in medical beliefs and practices among the non-conservatives was a socioeconomic one, not due to the extent of acculturation alone. The "Middle Class ethic" (Cohen 1955: 87) to which the higher status were looking as a model called for involvement in community affairs, unlike "Lower Class ethic" to which the lower status are directed (Cohen 1955: 94-97). The basis for such involvement is clearly phrased by Cohen and Hodges:

> Voluntary organizations characteristically, although in varying degrees, are concerned with the affairs of a larger community. To be able to appreciate these concerns assumes an ability to envisage events relatively remote from the immediate concrete situation and relationship between such events and one's own destiny (1963: 315).

Relating this to medical matters, the connection between the family and the community was more immediately perceived in the area of financing of medical services and the standard of treatment by the physicians than it was in the more abstruse area of the sanitation programs.

Although necessary, this pressure for involvement was not sufficient to explain the nature of the community commitments made by the two power alignments within the higher status. As defenders of the political status quo, the Council concentrated on attempting to maintain free medical attention. As innovators, the elite focused on the wider community need for improved sanitation. Ironically, the very crisis that the Council fostered to maintain cost-free medical services tended to crystallize for the reserve public the negative aspects of such care and convey the message that equally competent if not more personally gratifying treatment could be obtained off the reserve. The elite, on the other hand, were attempting to demonstrate that the sanitation facilities available off the reserve could and should be established on the reserve.

The forces exerted by both the elite and the Council were essentially pressures to equalize the standards of health care and sanitation between their reserve and non-reserve communities. In these health matters, as in their general style of life, the non-conservatives reveal that they are not so distinct as to merit being treated as a separate "culture." Their way of life is a sub-culture sharing many more elements of Canadian culture than conservative Iroquoian culture.

Plate XIII. Board of Health, 1967. Back row L to R: Donald R. Cassie (Superintendent), Richard Isaac (Chief Councillor), Frank W. Montour (Councillor). Front row L to R: Mrs. Rena Hill, Mrs. Mina Burnham (Councillors).

Addendum, April 1969

Although an analysis of the events following 1966 will be published elsewhere, a summary of recent changes should be given.

The Lady Willingdon Hospital finally closed its doors to all in-patients in September of 1968, but not before the Council had made several attempts to prevent its termination. Appeals to the Department of National Health and Welfare through a delegation sent to Ottawa and to their local Member of Parliament were unsuccessful.

The public health clinic still remains. It is supported by a medical clinic operated by two of the previous three physicians who remained in the federal service on the reserve.

The band Council has formally taken ownership of the hospital building and through its Board of Health is presently operating the Lady Willingdon Nursing Home. The structural alterations required by the province were financed and executed by the Federal Government, but the operating costs are borne by payments from those living in the Home. Only in cases where the individual is not able to meet the required fee does the provincial government make welfare payments to the Home through the individual. Any deficits arising are expected to be absorbed by the Council. In order to reduce over-expenditure if it arises, the Council has claimed it will admit non-Indians, but the statement has not yet been tested.

The Home has a capacity of 36 beds, the occupants of which cannot require constant medical attention under the licensing act. But if medical attention is required at any time either the two clinic doctors or a private physician can be called on, according to the individual's preference. Its staff, including the Director, is entirely composed of Six Nations people. Assisting the staff is a newly organized Women's Auxiliary which, it is hoped, will undertake some of the necessary sewing chores, and provide entertainment and companionship for the old people. Although the Home presently cares for people beyond retirement age, this is not the basic requirement. The Home was designed for the care of those who, because they are semi-bedridden, would make extensive demands on their families.

Secondly, the village water project, so long a point of contention between the elite and the Council, was taken over by the Council, and the system is now in operation. The installation cost of $250,470 for the purification plant and the piping system was borne entirely by the Federal Government. Potable water is obtained from a creek that flows near the village and transported to the houses of some 80 villagers, who must pay for the operating costs on the basis of the quantity consumed. To cope with the management of the system a Water Commission has been formed of villagers and Councillors to handle the business of billing residents, and a Six Nations man has been hired part-time to maintain the purification plant.

In March 1969 a Sewage Committee was formed by the villagers themselves to promote a sewage system, which may, in the future, be considered in conjunction with a more encompassing town planning scheme presently being explored by the Council.

Finally, the old doctor's residence, built in 1885 and recently remodelled, has become the Six Nations Public Library. The library has been

Plate XIV. Six Nations elected Council, 1968-1969. Seated at back, L to R: Richard Isaac (Chief), Donald R. Cassie (Superintendent). Seated in front, L to R: Councillors—Mrs. Rena Hill, Enos Williams, Leonard Staats, J. Clifford Lickers, Clarence Jamieson, Frank W. Montour, Ranson Jamieson, Mary Van Every (Council Clerk), Norman E. Lickers, Wm. Roy Longboat, Arthur W. Anderson Jr. (Welfare Officer), Victor Porter, Henry Fishcarrier (Secretary-Treasurer), George Bomberry. Absent—Nina Burnham.

operating since December 1968 under the direction of a band member. It was the product of the centennial project of the Ohsweken Women's Institute designed to provide more immediate access to books than that available in the nearby towns. The source for books is a loan system available to small libraries throughout the province. In April 1969 the Council replaced the Women's Institute management with its own Library Board, which must, in compliance with the financial regulations of the Federal Government, be responsible for its operations.

The pattern of sociocultural change evident in the establishment of the projects following 1966 differs in no respect from those prior to this date. The opposition between the Council and the elite will continue to arise so long as the drive for innovation and organization of new projects is located among the elite. For to finally institutionalize their innovations, they must gain the compliance of the Council, which is the only body legally able to obtain and disburse required funds. It is the role of the elite to initiate and launch new programs. It is the role of the Council, if its compliance is forthcoming, to maintain them. These roles are complementary; each is necessary, but not sufficient for innovation to occur at the community level.

Appendix A

The Religious Teachings of Handsome Lake

Following the American Revolution, the Iroquois who remained in New York State felt the pressure of westward expansion intensely. Their lands were desired and, through all manner of coercion, eventually obtained. Consequently dispersed into little "pocket" settlements, these units negotiated independently with the American Government, and only a semblance of League unity remained. Misunderstandings, broken promises and treaties, land purchasing companies, and settlers encroaching on their lands all posed a real threat to their security and existence as a separate nation and race. These critical experiences inevitably fostered feelings of distrust and hostility toward the Americans and enhanced Iroquois cultural disorganization.

In one of these small communities on the west side of the Allegheny River, a Seneca sachem named Handsome Lake experienced visitations from three "angels" who delivered to him the wishes of the Creator. These visions of 1799 set in motion a revitalization movement called "The New Religion," whose tenets continue today to be preached in the longhouses.

Although dreams as innovative forces cannot be denied (Wallace 1958), many of the innovations credited to Handsome Lake were in existance prior to his visions. The deep impact of Quaker teachings (Deardorff 1951: 89) and the Senecas' realization of their state of disorganization had led to these community changes.

The "Gaiwiio" or "The Good Message," which Handsome Lake preached for fifteen years, was and is essentially a moral and social code outlining in a very simple and explicit fashion the values and vices of life as revealed to him in his dreams.

Alcohol, witchcraft, secret medicine charms and meetings, and abortion were the "Four Words" he repeatedly stressed. These sins, and many others such as murder, gambling, and dancing to the fiddler's tune would be punished in the "House of Torment." On the more positive side, friendliness, hospitality, generosity, mutual aid and cooperation, and tolerance were desirable qualities in every person, not to be confined to family and relatives, but to be extended beyond even racial boundaries.

Kinship obligations were significantly confined to the nuclear family, not the matrilineal extended traditional form (Wallace 1961: 145-146). He prescribed harmonious relations between husband and wife, parent and child, adding that mothers-in-law should not interfere in the marital life of their children. Marriages, however, were still to be arranged by the mother's initiative. Gossip, jealousy, suspicion, and infidelity were considered sinful and fatal to marriage. Adoption was urged for childless couples, and harsh treatment of children was discouraged.

Comments on political life were restricted to criticism of quarrelling and personal slander among Chiefs. Their neglect of duty, illegal selling of Indian lands, and failure to set a good example for the community received strong censure. Handsome Lake stressed, moreover, that the white man had set aside lands for the Indian, and he reassured them that these lands would not be removed.

In the area of economics, realizing that their roles as hunters and trappers had become impossible to follow, he strongly urged the *men* to adopt the new agricultural methods and equipment. The traditional role of the women as horticulturalists was totally ignored. The men were to become the main breadwinners.

Religious and ceremonial changes were numerous. The aboriginal cosmology and pantheon were elaborated on and expanded by the addition of several concepts: a heaven, a hell, a personalized creator, angels, a devil with "horns, tail and cloven hoof," and the imminent end of the world (Wallace 1961: 145). Only four of the traditional religious dances were to be retained, and special clarification was given to the procedures of the Midwinter Festival and Thanksgiving Feast. A prescribed order of dances, prayers, and songs was carefully defined for each. Mourning practices were to be altered; the traditional period of mourning of one year was to be shortened to ten days. The aboriginal offices of the "Keepers of the Faith" and the sachems were kept, but were imbued with new duties of counselling the followers. In his own community, Handsome Lake incorporated two Chiefs into his religious structure to carry out censorship of public morals (Deardorff 1951: 89).

Relations between Indian and white man were to be accommodative and were carefully specified in the code. Regarding education, Handsome Lake had this to say:

> Now another message to tell your relatives. This concerns education. It is concerning studying in English schools. Now let the Council appoint twelve people to study, two from each nation of the six. So many white people are about you that you must study to know their ways (Parker 1912: 38).

Moreover, it was "right" to adopt three additional practices of the white man: the cultivating of the land, the building of wooden frame houses, and the keeping of horses and cattle. These practices were not only considered to be proper, but were to be encouraged, as long as pride did not become involved. Although no explicit reference was made to intermarriage with whites, he repeatedly stated that the Creator, by originally making several races, had intended that they remain separate.

It is significant to note that the acceptance of Handsome Lake's visions as "valid" and "true" made no unusual demands on the Iroquois because their traditional dream complex made for initial receptivity of ideas derived in such a fashion.

> In Iroquois theory, a dream could thus reveal the wishes not only of the dreamer but also of the supernatural who appeared in his dream. Frustration of the wishes of a supernatural was dangerous, for he might not merely abandon or cause the death of the dreamer, but bring about disaster to the whole society or even cause the end of the world (Wallace 1958: 246).

Another factor securing the "respectability" of the movement and the status of Handsome Lake as prophet was a letter from General Dearborn, sent to the Cornplanter settlement in 1802, in which he commended the prophet on his teachings. This letter was interpreted by the Iroquois as a "licence" to practise their religion and as an official recognition of the movement as a whole (Morgan 1962: 230), and "put him [Handsome Lake] beyond the effective reach" of the eastern Seneca who opposed the religion (Deardorff 1951: 95).

Finally, it is worth noting Wallace's observation (1961: 147) that much of traditional Iroquois culture was ignored in the code. The various vices, social relations with the nuclear family, and religious ritual and belief were the areas of greatest emphasis. Furthermore, value was placed on identification as Indian, not white, and during the time Handsome Lake was alive the teachings in this regard did not assume an aggressive tone.

The "Gaiwiio" or "Good Message," as outlined in Parker's code, has remained largely unchanged in its renditions in the longhouses. It constitutes the "constant" in the movement around which its meaning and function have varied (Wallace 1961: 148). Throughout the century and a half of its existence its interpretation has become less accommodative and progressively more nativistic and anti-white. Today it represents "the extreme of traditionalism" (Wallace 1961: 150).

Appendix B

Methodology

A total of a little more than twelve months were spent in the field from June 1963 to June 1966. For the duration of the data gathering stage, residence was established with a non-conservative family and, with very few exceptions, contacts made since June 1964 were with non-conservatives.

Methods of data collection were confined to participant observation and interviewing on the reserve and to systematic reading and recording of pertinent information from the hospital records in Ohsweken and the archival materials of the Indian Agency in Brantford. Open questions were preferred to closed questions in interviewing because of the desirability of gaining unanticipated information and of eliminating misleading answers from predetermined alternatives. Only during the first summer were interview data recorded while the interview was in progress. This on-the-spot writing was found to severely inhibit the free flow of information and for this reason was subsequently discontinued. Later notes were typed after the interview or in some cases quickly jotted down in the car before complete typing was done at home. During the last six months of field-work notes were written on 5-by-8-inch punch cards, thereby facilitating collation. It was regretted that these punch cards were not utilized throughout the period of data collection.

Rapport was soon established with the community leaders, but it was found that interviews with the women tended, on first contact, to draw out "the right answers," which I suspected to be statements of what they thought ought to be done rather than what was actually done. Questions, for example, pertaining to the frequency and procedure of purification of well water and sterilization of baby bottles brought the "correct answers" (i.e., the advice given them by public health personnel), and only during the second or third interviews did the facts emerge that, although the proper procedures were known, for a variety of reasons they were not always followed. Efforts to convince a few women that I was not a judge of their actions sometimes proved difficult, and in one case after the interview was terminated the mother remarked: "There, that should satisfy your government."

Informants were not paid for their assistance, but small gifts were often given. These gifts were usually things that had been mentioned in the conversation as items they had been intending to purchase but had never done so. Crafts were often purchased from those who produced them for sale. In some situations no material payment was given at all with the belief that such would have harmed a relationship in which information had been freely and willingly given in the genuine interests of the research project.

My original introduction to the field situation in 1963 was made as a student of Dr. Fred Voget, then of the University of Toronto. It was he who gained the Council's permission for me to reside on the reserve. In the subsequent years I sent a letter to the Council requesting similar permission and followed this by an appearance at the Council meeting when the issue was raised and voted upon. Permission to establish temporary residence was always granted.

History of medical services, 1784-1950

Material on the medical administration of the reserve from the immigration in 1784 to the 1850's was derived from secondary sources, primarily Johnston (1964). Most of the data from 1850 to 1950 was obtained by reading the Council Minutes and extracting information under the following general headings: the triadic relationship among the Chiefs (after 1924 referred to as Councillors), the Agency Superintendent, and the Medical Superintendent; the fashion in which new ideas pertaining to medical administration were introduced to the Chiefs; the loci of stimulation for change among the Six Nations; the Chief's reception of such proposals; crises such as epidemics; welfare payments made due to illness; decisions to refer patients to outside medical services; annual reports of the Board of Health and the Hospital that were read to the Chiefs; quarterly and annual reports by the physicians; physicians' salaries and drug allowances; Chiefs' expectations of a physician's role performance and assessments of actual performance; petitions by the population relating to medical matters; and special hearings of Council pertaining to medical affairs.

In addition, the correspondence of the Agency Superintendent and the Medical Superintendent relating to the medical administration of the reserve and the state of health of the Six Nations was searched in the Agency's archives. This correspondence of the above federal employees provided interesting evaluations of the Six Nations response to externally originating pressures to change and of their own drive for expanded services. The difficulty of obtaining new equipment for the physician's office was made abundantly clear in these records, as was the difficulty of expanding the number of physicians serving the reserve.

Several older informants were questioned for their knowledge of the medical administration on the reserve at the turn of the century and in particular about the composition and duties of the Board of Health (1901-1924) and the Hospital Board (1908-1913), and the conflict in the triadic relationship among Chiefs, physicians, and the Agency Superintendent. The discontent so evident and repetitive in the Minutes was, however, not remembered as existing to any extent publicly by the older informants. That this conflict was part of a broader conflict over the autonomy of the Council, and hence primarily a political issue, is undoubtedly the reason for the lack of public awareness. One older informant (Hilton M. Hill) attended the special meeting of Council in 1900 when the idea of a Board of Health was proposed to the Council, and his statements have been recorded in the text. It is truly unfortunate that the "Minute Book" of this Board alluded to in the Council records could not be located, or its existence even remembered by the older informants.

The period between 1927 and 1950 was documented very sparingly in the Council Minutes and the Agency correspondence. The bulk of information was obtained from interviews and from hospital records which, when available, were very meagre.

Data on the medical administration involving abrupt changes in policy during this period were gained from records and interviews. Informants were asked about their knowledge and opinions of the expansion of the hospital, their evaluation of the hospital's new policies, their recent experiences with consultation at the hospital, the frequency and cause of use of outside physicians, the desirability of medical insurance, and their ideal requisites for judging a physician's performance. Since "the hospital" and the recent (1962) "trouble" were very much topics of concern to the people most were very willing informants. The phrases used to describe the "hospital situation" were found to be very standardized, in spite of the different socioeconomic levels from which the informants derived.

Hospital personnel were interviewed, both formally and informally, to obtain information on the changes in building accommodation and policy over the past sixteen years. In four interviews arranged between 1963 and 1966, data on the exact billing procedures and policy were obtained from the business administrator, as was information on personnel additions and reductions and the hospital's relationship with the Hospital Committee, the Health Committee, the Complaints Committee, and the Council. As well as the physicians, the business administrator was questioned regarding the "March hearing" in 1962, at which the Council presented residents' malpractice charges to a panel of resident physicians and an administrator from the Department of National Health and Welfare brought from Ottawa. The "other side" of the malpractice hearing was investigated by interviewing Councillors and two of the individuals who had presented complaints. All the complaints presented to the Council originally in writing were read and recorded.

All the resident physicians were interviewed and, with two exceptions, the contacts were informal, most of them taking place in the physician's spare moments while on duty at the hospital and after regular visiting hours. Questions asked them fell under the following headings: their assessment of the general state of health of the Six Nations, the most frequently reported ailments, physician and patient use of anatomical terms during consultation, their opinions on the ideal and real performance of a patient role, their knowledge and assessment of new hospital policies, and any changes they had noted during their period of employment at the hospital, including differences in patient attitude toward the physician, and types and frequencies of reported aliments. Information on the ethnic and academic background of the physicians employed at the hospital since 1950 was obtained from the federal office in Ottawa.

The two public health nurses who provided invaluable assistance throughout the study were freely consulted. A visit to a Well Baby Clinic with a nurse provided an opportunity for interviewing the mothers and observing the regular procedures. One morning was spent with the same nurse in her routine examination of school children in a village school. An additional afternoon was spent interviewing twelve women as they passed from the waiting room to the nurse's office for their prenatal examinations.

Hospital records were extensively

used to validate information from all informants (medical and non-medical) and to obtain additional and more detailed data on the hospital's growth and on the physicians' reactions to the response of the Six Nations to new policies. Annual reports of the hospital and monthly attendance records for in-patients were consulted in detail for the years between 1950 and 1966. Standard information, such as the annual attendance of out-patients and in-patients, the number of individuals using the hospital on an annual basis as out-patients, the number of beds set up and actual bed capacity, and the number of house calls, was recorded, as were any descriptive passages ("narratives") recounting major events of the past year.

Informants were generally very willing to discuss health matters: recent and past illnesses in the family, measures taken and by whom to alleviate the condition, attitudes towards medical personnel, the basis for selecting persons outside the family for information or assistance, and so forth. To questions on the specific cause of certain ailments, however, the response was not too satisfactory. "Some kind of germ, I guess" was the common reply, and one to be expected since many simply did not know what caused certain illnesses. Informants were very uncertain of the validity or acceptance of their theories of causation, and it was felt by the field-worker that they, being equally aware of the complexity of causation abounding in the professional medical world, were reluctant to offer their ideas. This reluctance was particularly well manifested in one instance when a woman was asked what she thought might be the cause of cancer. The conversation had begun with a discussion about a family friend who was presently terminally ill with cancer. The woman replied that she did not know what could cause cancer, but her husband then offered the suggestion that the friend had a dog that had cancer and "maybe" he had "got it" from the dog. The wife immediately rebuked the husband for "saying such things when you don't know."

Indecision about causation among older informants was often made clear when they would answer, citing a folk theory. In one such case the informant was asked what he thought caused sties on eye rims. He answered by stating, "They used to say it was a sign that you had been walking the roads at night." When asked if he believed this saying, he remarked "I don't know, there may be some truth in it." An older woman, when asked what she thought caused epilepsy, remarked "In the older days they said it was because the child's parents were bad: they hadn't been faithful to each other." When asked if she thought this was the reason, she said "I don't really know what to think."

Among the non-conservatives, vagueness was again apparent in their descriptions of the parts of plants to be used in Indian remedies. Although some could be specific as to roots, bark, stem, leaf, or flower to be used, others frequently claimed that you simply "used" a certain plant. When asked what parts, they commonly answered, "All of it, I guess." This imprecision equally applied to the plants themselves. Species distinctions, although perhaps visually recognized in the different species of plantain growing in their lawns, are not made in references to herbal remedies.

It is interesting to note that some of the non-conservatives are very eager to learn of the Indian remedies. With few exceptions all informants could offer at least one herbal remedy, and some stated they regretted not having paid greater attention to the Indian cures their parents spoke about. Although some of these cures have been used by the non-conservatives, their desire to learn of them reflects their attempt to prevent, as they say, "Indian culture from dying," more than their desire to use them either to prevent or cure illness.

In addition to direct questioning, data were gathered by analysing personal medical histories at the hospital. Eighty-eight (twenty-eight adults and sixty children) individuals' records, representing fourteen families (five higher status and nine lower status), were recorded to obtain some indication of the nature of use of the local hospital. For each adult the medical history ideally covered a fourteen-year period—from 1952, when personal medical histories were first kept, to 1966. For each child, the record covered the duration of his life, subject, of course, to gaps, as were the adult records for periods of residence off the reserve. The selection of the families was based on comparable age ranges for adults (33 to 46) and children (10 months to 22 years). The higher status sample was necessarily smaller because of the need to select according to similar age among adults, which eliminated many because they were older than the lower status and because the younger higher status families have their own private physicians in the nearby towns (*see* Table 9, p. 135).

Status groups

In the course of questioning about families who did participate in voluntary associations, such as the various health and sanitation committees, it became apparent that informants sorted families into two categories on the basis of "caring" (i.e., adhering to the Protestant ethic) and "contributing" (i.e., joining and participating in the various community activities). Using both the reputational approach (informants' personal evaluations of the social standing of families) and observation, two major status categories were delineated and termed higher status and lower status.

The higher status were seen to care and contribute, and the lower status, although containing some families who "tried" (attempted to live by the Protestant ethic, which espouses the values of hard work, industriousness, sobriety, marital fidelity, cleanliness, and deferment of gratification), were seen to fall short of both these goals. Within the higher status, moreover, it became obvious that families were differentiated according to their form of contribution. A group of some eighteen families formed an easily observable unit, whose members maintained long-term membership and leadership roles in several of the voluntary associations. Unlike the remaining higher status families, these collectively termed the "elite," formed an interacting group, who placed particular emphasis on community participation that ideally brought no financial remuneration and that as a rule did not directly involve local government.

The non-conservative families on which data were collected were selected primarily on the basis of participation in community affairs, which included the health and sanitation committees. These activist families numbered thirty. In addition, data were obtained on fourteen lower status families, although the degree of detail achieved for the higher status was not sought here because of the minimal role these individuals played in health activities at the community level. Selection of these fourteen families, aided by information supplied by the public health personnel, was made on the basis of income and effort to adhere to the Protestant ethic, in the opinion of the higher status. Thus this sample included economically viable and unviable families, and those which were said to "try" and those which were said to have seldom "tried." Information on the lower status was obtained primarily to provide a more expanded background of socioeconomic factors among the non-conservatives; it was not designed to be definitive.

Although the status system could not be claimed a rigid one in the sense that there were a few families considered "border-line," the terms used by the higher status leaders to indicate categories were frequently identical (i.e., "caring," "trying," and "contributing"), and there was close agreement among informants as to who belonged near the "top" and the "bottom."

The criteria used by the lower status for differentiation were limited to believed or observed wealth, occupation, and authority within the community. Moral character was not given the weight that it had among the higher status, although some of the lower status informants were quick to point out that some higher status were not so "good as they

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[1] Status groups as used in this study refers to a category of families grouped on the basis of similar social standing. As such, it does not imply interaction of those individuals in any form of a cohesive group.

think they are." Participation in community affairs and endeavour were not considered as significant as they were among the higher status informants.

The criteria used by the higher status to delineate the categories were more numerous and more explicit than those given by lower status informants. Their criteria included income, occupation, tenure of employment, education, spending patterns, style of life, moral character, participation in community activities, values of hard work, ingenuity, and economic independence of the nuclear family.

The elite and the non-elite higher status informants' views of the non-conservative community did not differ to any great extent. The criteria that separated the elite and the non-elite within their own status group—the form of community contribution and, in some cases, the respected family history—did not enter into differential assessment of the remaining families, since these families did not involve themselves in community activities, nor did they have prestigious ancestors. The non-elite were as sensitive to the factor of endeavour, that is "trying," as were the elite, if not more so, but tended to give greater consideration to the difficulties families had in coping with life (i.e., large number of children in the family and the use of income for alcohol). This greater accreditation given some of the lower status families[2] did not produce a lack of consensus between elite and non-elite in their respective evaluations, but it did indicate a somewhat greater tolerance and understanding of their life situations.

It became very apparent that, although material style was a factor in the status system, it did not have an overwhelming influence over the other criteria. The intangibles rather than the tangibles were more significant. Since income and occupation, factors allowing for the consumption of material items, were not of singular importance, the categories recognized by the informants have been termed status groups rather than classes, which in traditional analysis have rested primarily on wealth and occupational criteria. On the basis of the data obtained, and not unlike status groups in Euroamerican society (Mayer 1955: 25), these non-conservative groups do not correspond neatly to groups derived from purely economic considerations. Incomes and type of occupation overlap, for example, between some lower and higher status families including the elite; skilled and unskilled labourers are found in both status groups. This is not to deny the importance of professional or white collar positions of the higher status, for this, in addition to fostering pride in the family, indicates to the non-conservatives that the Indian can successfully compete in a white man's world. It simply means that, given professional status or a solid income, there must be complementing factors before an individual or his family is given a social position in the community. Categories based on wealth and occupation alone have no "social reality" for the non-conservatives.

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[2] In the original analysis (Weaver 1967) this group of lower status families who were seen to "try" were given formal recognition as a status category and designated the middle status. Since this monograph is concerned with those who engage in community activities regarding health and sanitation, and since the middle status did not, they have been placed in this study with the lower status and given the latter term, consequently rendering this category more heterogeneous in quality.

It should also be noted that the higher status terms of reference (caring and contributing) not only are meaningful from a social ranking viewpoint within the non-conservative community, but also enter into their feelings regarding the white man's image of the Indian. Those who are sensitive to their image as being generally derogatory deeply resent the indiscriminate stereotyping of Indians. This particularly refers to the white man's lack of recognition or knowledge of their "better class of people" on the reserve, who do not deserve to be so stigmatized. The selection of items to receive publicity in local newspapers only serves to maintain this image, to the annoyance of the elite in particular. News items involving drunkenness and crime among Indians invariably receive greater attention than do community affairs of a productive nature, such as a banquet held to honour high school and university graduates. This selectivity in reporting, however, is recognized by the elite as being a general characteristic of journalism, not a feature relating only to Indians. Their desire to destroy this negative image possibly inhibits the more explicit use of uncomplimentary terms of reference for some of the lower status people, particularly those who are, in their estimation, "always ready for a hand-out" and who are adept at exploiting the welfare services, for it is the latter individuals who serve, in part, to maintain this undesirable image.

Higher status category

The total sample of higher status families is thirty. Sampling was weighted in favour of the elite because of their singular role in community health activities, and, as a result of this selecting, the average age of 58.8 is some fifteen years more than that of the lower status sample.

The total number of elite families residing on the reserve at the time of writing was eighteen. Fifteen of these comprise the elite sample; each family was interviewed from one to ten times with an average of four times, and each interview lasted from one to four hours. The three remaining elite families are known to the writer through meetings at formal gatherings such as the Women's Institute, the Fair Board annual summer picnic, and the Fall Fair. General information on these three families was obtained from Agency and hospital records. In addition to these formal interviews many equally productive contacts were made informally over coffee in the local restaurants, at lunch in a local craft shop, and during the three months spent in the Indian Office analysing the Council Minutes.

In addition to the active core elite mentioned above, there is a group of ex- or retired elite recognized by the higher status group; in total they number approximately eight families in each of which only one spouse is now living. Three of these eight were interviewed from one to four times.

The total number of non-elite higher status families on the reserve is not documented; a sample of twelve families was studied during the fieldwork. A total of twenty-eight interviews were made, averaging a little more than two interviews per family. An additional seven families are known through Agency and hospital records, but these data are not included in the description presented.

Considering the higher status as a whole, of the total of thirty families twenty-seven are couples with children, two are childless, and one is an unmarried woman not living with her parents. The total potential number of adults in this sample is sixty, of which fifty-two are living. Thirty-one of these sixty are women. The age range of these living adults is from thirty-seven to eighty-six years, with 58.8 being the average age. Of the total of 104 children born to these twenty-seven couples, ninety-six are living. Two children died in infancy, two in adolescence due to accidents, and four in adulthood due to combat in World War II. The average number of children born to productive couples was 3.8, and the average number of living children per couple was 3.5, as was the average number of children of the total of thirty families. The age range of these children was from 9 to 56 years with the average being 34.1.

All the higher status families own their own houses. Their formal education ranges from grade eight through hospital and teachers' college training to university. The women have received more education than the men and as a group have a higher percentage of professionals (41.9) than the men (10.3).

Of the total of twenty-nine men in the sample (some of whom are now dead), the majority are farmers and labourers. Eight farm, full time on the reserve, and eight are labourers, both skilled and unskilled. Six of these eight work on the reserve (primarily as maintenance men in the schools), and two work off the reserve in industry. Three men are professionals (all teachers on the reserve), and two are local entrepreneurs. One man in ill-health is unemployed; another, who worked as a civil servant in a municipality some miles from the reserve, is now retired at home. Of the six men who are white collar workers, five are involved in administration of local Indian affairs; the additional one was a salesman who earned his living in the United States and then returned to the reserve to retire. Of these twenty-nine men, nineteen are presently working, one is unemployed, six are retired, and three are deceased.

Of the thirty-one women in the sample, nineteen have worked permanently for most of their lives. Thirteen of these women are professionals: eight are school teachers and five are nurses. All but one work on the reserve. One is a white collar worker who was employed off the reserve for many years before returning to retire. Three women are nurses' assistants at the local hospital, and one is a hair stylist. One woman is self-employed on the reserve. The remaining twelve women have not been employed.

Most of the higher status families are Anglican. Of the thirty families, twenty-one claim this adherence, five claim Baptist and four United Church. None is Pentecostal. Fourteen of these families are regular attenders, often being described as the "pillars of the church." Their participation includes not only Sunday attendance, but involvement in the choir, the business and building boards, Sunday school, women's guilds, and church socials. The rest of the families tend to be sporadic attenders, but all have sent their children to Sunday school.

Lower status category

The sample comprises fourteen families and represents both economically viable and unviable families. Of the fourteen, eleven are represented by interview materials and data from the analysis of records, and the remaining three by records in the Indian Agency and hospital and by interviews with public health personnel and the welfare officers. That self-introductions, in the case of three families, proved impossible to make is strongly believed to be a product of the type of personnel who quite regularly visit these homes. Many of these persons are either medical or welfare personnel (i.e., Children's Aid, the Welfare Officer, and the Welfare Committee of the band Council) whose job it is to suggest or effect alterations in the home setting (i.e., temporary custody of children, placing of children in the hospital, inspections of Council-owned houses). I was seen in these types of roles; this either prevented contact being made or coloured the data when interviewing was possible. By accompanying a public health nurse[3] in visiting one of these families, I was cast in the role of government medical personnel. Although this undoubtedly introduced some bias into the material obtained, it allowed data to be gathered on that family that would otherwise not have been procurable.

Rapport was more easily established with the ten families not accustomed to intervention of public personnel. Women were the primary informants in this category, and on the second or third interview they were found very willing to discuss almost any topic raised, with the exception of birth control, an area in which they were obviously ill at ease.

Of the eleven non-conservative lower status families personally interviewed, sessions ranged in number from two to ten, averaging slightly over five interviews per family.

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[3] In addition to visits made to lower status non-conservatives, visits were made with the public health nurses to three families of conservatives, considered lower status by informants. The observations and interview materials, although not utilized in this section, provided some indication that conservatives and non-conservatives cannot be distinguished at this socioeconomic level of welfare dependency. This is not to imply that all conservatives would manifest the attributes of this status group; some that are known to the writer most definitely would not. But it does appear to underscore the claim that poverty tends to be a dissolvent of cultural differences. As Lewis (1961: xxiv) has stated: "The culture of poverty has its own modalities and distinctive social and psychological consequences for its members. It is a dynamic factor which affects participation in the larger national culture and becomes a subculture of its own."

Data for this chapter come from interview materials and recorded minutes of the three sanitation committees. All minutes of each committee were recorded and used as question guides in interviews. Six Nations informants in both leadership and nonleadership roles were questioned as to the history of the committees, personal evaluations of their successes and failures, and the attributed reasons for achievement of goals or lack of achievement. Interviews similarly conducted with representatives from both the Council and the hospital to these committees revealed disparity of objectives and means to meet these objectives among the three types of participants. Newspaper clippings pertaining to the 1962 hospital crisis were obtained from one informant. Council Minutes were found to provide exceptionally little of the course of events that occurred over the past few years, including the malpractice issue. The federal medical officer for the region including the Six Nations Reserve was interviewed regarding the "hospital trouble," and the federal sanitation supervisor for this same region provided additional information on the sanitation program on the reserve.

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